



2022 Hospital and Non-Hospital Reporting Manual

Tenth Edition

Arkansas Central Cancer Registry
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PREFACE – ABOUT THIS MANUAL

Public Law 102-515 and the Arkansas Central Cancer Registry

The Arkansas Central Cancer Registry (ACCR) Facility Reporting Manual has been created to assist hospitals, treatment centers, clinics, and physician offices in reporting cancer cases to the central cancer registry. This is the tenth edition (2022) of this manual and it is being implemented to meet the requirements from the Center for Disease Control and Prevention's (CDC) National Program of Cancer Registries (NPCR), the North American Association for Central Cancer Registries (NAACCR), the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) program, and the Commission on Cancer's (CoC) Standards for Oncology Registry Entry (STORE). There are also clarifications and rules that are in place, in order to accurately complete abstraction of cancer cases. Implementation of this manual is to begin with cancer cases diagnosed as of January 1, 2022.

The Arkansas General Assembly originally established the Arkansas Central Cancer Registry (ACCR) in 1938. The registry only collected minimal data and was only for indigent patients who were referred to participating tumor clinics throughout the state of Arkansas. No funds were available from the state until 1945. By 1970, the data collected was computerized, but due to a state-funding crisis in 1979, The Arkansas Central Cancer Registry was eliminated.

In 1989, Arkansas again authorized a state cancer registry to be located at the Arkansas Department of Health, although funding was not available to staff the registry or collect the data. In 1992, The United States Congress passed the "Cancer Registries Amendment Act" (Public Law 102-515), which provided federal funding for state cancer registries. The law was carried out through efforts by the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Funding for a cancer program in Arkansas began in 1994, when the first federal funds were awarded through the National Program for Cancer Registries (NPCR).

NPCR requires central registries to:

- Collect incidence data on all patients diagnosed and/or receiving first course of treatment in the registry's state, regardless of residency;
- Have legislation mandating the reporting of cancer cases by all facilities diagnosing and/or treating cancer;
- Provide training for central registry staff, hospital registry and non-hospital reporting facility staff,
- Collect information on cancer cases in a standard data format;
- Produce data within 12 months of the end of the diagnostic year with at least 90% ascertainment;
- Produce data within 24 months of the end of the diagnostic year with at least 95% ascertainment;
- Conduct case finding and re-abstrating audits to determine the completeness and quality of all cancer cases being submitted to the registry;
- Conduct case-finding, re-abstrating, and re-coding text audits to determine the completeness and quality of all cancer cases being submitted to the registry.

In 1994, the Arkansas Board of Health mandated cancer as a reportable disease in the State of Arkansas. The reference date for the Arkansas Central Cancer Registry is January 1, 1996. This is the first time since 1979 that cancer data was collected in Arkansas.

The ACCR:

- 1) Collects data that are compliant with required NPCR data elements;
- 2) Meets standard requirements designated by NPCR, SEER, and NAACCR for incidence reporting;

- 3) Assists in determining data quality;
- 4) Provide useful information, feedback and assistance to submitting facilities;
- 5) Provide aggregate data on cancer incidence for public consumption; and
- 6) Provide data to researchers, as approved by the State Board of Health, in an effort to reduce the cancer burden among Arkansans.

Data is submitted annually to NPCR and to NAACCR for registry certification and publication in Cancer in North America (CINA). Registries that submit data that meets established criteria of timeliness, accuracy and completeness are recognized annually as Silver or Gold Certified registries by NAACCR.

INTRODUCTION

ARKANSAS CANCER REPORTING REQUIREMENTS

Arkansas State reporting laws, NPCR standards, data quality and projected needs of the citizens of this state govern reporting requirements. This manual is for the intended use of all facilities who diagnose and/or treat cancer in Arkansas. The statutes also include facilities that provide diagnostic or therapeutic services, screening, patients diagnosed and/or treated as hospital in-patients, outpatients and in non-hospital facilities (e.g., pathology laboratories, ambulatory surgery centers, physician offices, freestanding treatment centers and long-term care facilities) in an effort to maintain a high-quality population-based central registry.

Facilities are required to report all malignant, specific in-situ cancers and reportable benign brain and central nervous system tumors to the Arkansas Department of Health/Arkansas Central Cancer Registry (please see Appendix F for the full reportable list). ACCR follows the collection rules of the following standard setters: the North American Association for Central Cancer Registries (NAACCR), the Commission on Cancer's Standards for Oncology Registry Entry (STORE), and Surveillance Epidemiology and End Results (SEER) program of the National Cancer Institute. Data requirements are based on fields required by the National Program of Cancer Registries (NPCR) at the CDC in addition to Arkansas state required fields.

ROLE OF FACILITIES

The hospital cancer registry is the primary source for obtaining epidemiological information. A registry is responsible for providing a listing of cancer patients and pertinent information regarding their disease. A registry may be small or large, and the extent of submission of information is varied, depending on hospital size and the reporting methods for each facility. For smaller facilities, the ACCR has provided an abstracting and reporting tool called Web Plus. Web Plus is a free, web-based software developed by the NPCR at the CDC and supported by the ACCR. The ACCR provides training to facilities for use of the Web Plus. Hospital based laboratories and private or independent laboratories licensed in Arkansas must report all required cancer cases in an HL-7 formatted file. There are multiple secure mechanisms for transferring this data to the ACCR. The method by which a facility, hospital, or pathology laboratory submits data is at the discretion of the ACCR.

ROLE OF ARKANSAS CENTRAL CANCER REGISTRY WITHIN THE ARKANSAS DEPARTMENT OF HEALTH

The role of the ACCR is to gather information from hospitals and other sources to monitor the incidence of cancer in the state, to develop and evaluate cancer prevention and control through epidemiological research, and to provide training to facility staff for reporting purposes. The data is received in abstract form, electronically from hospitals. The information is valuable in determining risk factors, environmental impacts, ethnic and social variations as well as effectiveness of state cancer control programs.

CONFIDENTIALITY

According to State Cancer Law (20-15-202) "Information accumulated and maintained in the Arkansas Central Cancer Registry shall not be divulged except for statistical information that does not identify individuals and for purposes of research by a qualified researcher. As used in this section, "qualified researcher" means a researcher from a recognized institution, including without limitation an academic, state or federal government, or nonprofit nongovernmental institution, and who is adequately trained about conditions where names and identities of individuals are appropriately protected while conducting research for the purposes of cancer prevention, control, and treatment." The rules and regulations also state "All information

reported to the Department of Health shall be confidential and shall not be disclosed under any circumstances except (1) to other state cancer registries with which the Department of Health has agreements that insure confidentiality; (2) to other state health officials who are obligated to keep such information confidential; and (3) to approved cancer research centers under specific conditions where names and identities of the individuals are appropriately protected, and when such research is conducted for the purpose of cancer prevention, control and treatment”.

ACCR staff are required to sign confidentiality agreements and follow confidentiality procedures as stated in the Arkansas Central Cancer Registry Policy and Procedure Manual. This also includes secure electronic access, fire resistant, locked file cabinets for confidential data, procedures for handling requests for data and policies for handling breaches of confidentiality.

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) allows for the reporting of identifiable cancer data to public health entities. Because ACCR falls under the definition of a public health authority, HIPAA allows your facility to continue reporting cancer incidence data in compliance with the current state statutes (20.15.201 – 20.15.205). Written informed consent from each cancer patient reported to public health entities is not required under HIPAA nor is a Business Associate Agreement required; rather, hospitals must simply document that reporting has occurred.

AUDITS

ACCR Quality Assurance Coordinator conducts annual oversight of case-finding and quality assurance (re-abstracting and re-coding text) audits as required by NPCR. The purpose of these audits is to ensure that all reportable cases are being identified and reported to the Central Registry and that all information submitted to the registry is of good quality and accurately coded.

The audits are scheduled in advance to ensure the facilities adequate preparation time for the impending audit. After completion of audits, a report is provided to the facility cancer registry director or reporting administrator and CEO, which summarize the percentage of case ascertainment or completeness and any suggestions that would help to improve the reporting process.

Case-Finding audits are performed on inpatient and outpatient disease indices, pathology reports and other pertinent case finding documents such as: clinic sign-in logs, and surgery logs. These documents are reviewed and all reportable codes are compared to the facility information housed in the ACCR database. All cases that are not identified in the database will have to be reconciled by the registrar at the audited facility. The registrar will have a minimum of 14 days to complete the reconciliation process and return an updated list to ACCR with reasons why the identified cases were not abstracted or if the cases are reportable and were missed during the original abstracting period.

Cases that are reportable but were missed must be abstracted into their database and submitted to ACCR. All cases diagnosed before January 1, 1996 or cases not diagnosed or treated at the reporting facility are removed from the reconciliation log and a percentage is calculated at that time. A report is sent to the cancer registry supervisor and the administrator of the facility that summarizes the percentage of case ascertainment and provides suggestions to help improve the case ascertainment process.

Quality assurance or re-abstracting audits consists of re-abstracting specific fields selected by ACCR and are compared with the original data that has been submitted. Any discrepancies are documented and sent to the audited facility in a summary report. Exceptions are taken into consideration, (i.e. if a case has been merged/consolidated in the ACCR database and the audited facility did not have this information, which

could indicate that the other procedures were done elsewhere and not available to the audited facility at the time the case was abstracted).

Re-coding text audits consists of a review of a random sample of cases from the facilities. The re-coding audit will review the text in the abstract from the facility and re-abstract according to cancer registry rules, guidelines, standards, and text available.

Chapter 1 – General Instructions

Basic Rules for State Reporting

Important Items for Reporting:

- Facilities are *required* by Arkansas statute (§20.15.201-205) to abstract inpatient and outpatient cancer cases.
- All reportable cancer cases diagnosed and/or treated in facilities after January 1, 1996, must be abstracted and reported to ACCR by the facility staff or contractor.
- All required data items should be *collected and reported* to ACCR. The list is based on the rules and regulations stated in the Arkansas statute, NPCR, NAACCR, SEER, and CoC.
- Electronic reporting, in the method outlined by ACCR, is required for all facilities regardless of size. ACCR does not accept paper medical records or abstracts.
- Solid tumors diagnosed on or after January 1, 2018 MUST be abstracted according to reportability and coding instructions set forth in *The Solid Tumor Coding Rules Manual* which can be downloaded from <https://seer.cancer.gov/tools/solidtumor/>. For Cutaneous Melanoma cases diagnosed on or after January 1, 2021 use 2021 Solid Tumor Cutaneous Melanoma rules. Use 2007 General Instructions, Other Sites for cases diagnosed 2007 – 2022 and beginning in 2022 and forward use *Solid Tumor Rules*. Solid tumors diagnosed from January 1, 2007 through December 31, 2017 are to be abstracted according to *The Multiple Primary and Histology Coding Rules Manual* which can be downloaded from <http://seer.cancer.gov/tools/mphrules/download.html>
- For cases diagnosed on or after January 1, 2021 the ICD-O-3.2 coding scheme in conjunction with the *Solid Tumor Coding Rules* must be used to code site and histology (<https://www.naaccr.org/icdo3/>). The ICD-O-3 coding scheme *must be used* for site and histology for cases diagnosed on or after January 1, 2001. The ICD-O-2 coding scheme must be used for cases diagnosed prior to January 1, 2001.

Note: Hematopoietic malignancies are coded according to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the *Hematopoietic Database* for cases diagnosed on or after January 1, 2010. For cases diagnosed on or after January 1, 2015 use the current version which can be downloaded at <https://seer.cancer.gov/tools/heme/download>.

- Beginning January 1, 2022 record the SSDI data item p16 for cervical cases (C530-C431, C538, C539)
- For Head and Neck sites a p16 test result can be used to code squamous cell carcinoma, HPV positive (8085), and squamous cell carcinoma, HPV negative (8086) beginning January 1, 2022.
- **Please stay abreast of revisions to manuals by periodically checking websites specific to the following standard setters: SEER, CoC, NAACCR, AJCC, and NPCR.**
- Completed cases must be submitted to ACCR within six (6) months after date of initial diagnosis.
- All pathology reports that are read by hospital pathology laboratories must be forwarded to ACCR.
- Occasionally, hospitals require special data reports from the central registry. Requests for studies, reports or information should be submitted on a data request form. To access this online data request form at the following website: <https://www.healthy.arkansas.gov/programs-services/topics/arkansas-cancer-registry>.
- It is important that all reporting facilities submit data in a timely manner, to ensure the availability of data during the merging and de-duplication process. The requirements for data submissions are monthly reporting of cases.

- All facilities submitting data are required to perform EDITS on these cases to detect any errors that may exist. Upon arrival to ACCR, all files will undergo additional edit checks. If the file contains an unacceptable number of errors, it will be returned to the facility for corrections. A summary report of the errors is automatically sent to the facility with the rejected file. The facility will be given a maximum of 14 days to correct all errors and return the data file. For those using Web Plus, the ACCR EDITS are built into the software requiring the abstract to be clean before it can be released. For facilities submitting via meaningful use, EDITS is used in the validation of the CDA. If errors are detected the CDA will be rejected.

Who Must Report

A. Health Care Providers

1. All health care providers who diagnose and/or treat cancer patients must report confirmed cases of cancer to the Arkansas Central Cancer Registry (ACCR). The types of providers listed below are included in this requirement.
 - a. Hospitals
 - b. Physicians
 - c. Dentists
 - d. Medical laboratories
 - e. Freestanding radiation or medical oncology clinics
 - f. Ambulatory outpatient surgical centers
 - g. Nursing homes
 - h. Other health care facilities, such as freestanding mammography or other radiology facilities, hospices, etc.

B. Determining Responsibility for Reporting

1. Physicians must report all required cancer cases that are not referred to a hospital for further diagnosis or treatment. This includes:
 - a. Patients who are clinically diagnosed and receive no further work-up or treatment
 - b. Patients who are newly diagnosed in the physician's own laboratory facility or by sending a specimen from the office to an outside laboratory, whether hospital or independent
 - c. Patients whose first course treatment is initiated in the physician's office or clinic. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.
Exception: If a hospital reports cases diagnosed and/or treated in a staff physician office, the physician need not duplicate this case to ACCR.
2. Dentists must report all required cancer cases that are not referred to a hospital for further diagnosis or treatment. This includes:
 - a. Patients who are diagnosed and/or treated by a dentist who performs a biopsy and/or receives a pathology report of a malignant diagnosis
 - b. Cases also reported by either hospital based or private/independent medical laboratories
3. Medical Laboratories: Hospital based laboratories and private or independent laboratories licensed in Arkansas must report all required cancer cases diagnosed in the lab in an HL-7 formatted file. This HL-7 file must conform to the standard required items as set by the ACCR.
4. Freestanding Radiation or Medical Oncology Clinics must report any patient initially diagnosed with a reportable cancer and/or when first course treatment is initiated at the non-hospital based facility. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.
5. Surgery Centers: Freestanding surgery centers (independent centers not affiliated with any hospital) must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly

diagnosed reportable cancer. This includes cases reported by either a hospital based or private/independent medical laboratory as described in paragraph 3 above. Surgery centers affiliated with a hospital must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer if the patient was not referred to the hospital for further diagnosis or treatment. This includes cases also reported by either hospital based or private/independent medical laboratories as described in paragraph 3 above.

6. Nursing Homes must report the following types of newly diagnosed reportable cancer cases. Nursing homes should identify all patients with a cancer diagnosis at the time of admission, even if diagnosed and treated prior to the admission. The facility should send copies of pertinent medical records relating to the diagnosis to ACCR. This includes:
 - a. Cases clinically diagnosed but not confirmed through biopsy, cytology, or other microscopic methods
 - b. Cases for whom the first course of treatment is initiated at the facility. Treatment may include chemotherapy, immunotherapy, or hormone therapy.
7. Mammography or Other Radiology Facilities that provide screening, diagnostic, or therapeutic cancer services must report confirmed reportable cases of cancer.

Changing Information

It is possible that after a case has been submitted to the ACCR, additional information added to the patient's chart would change specific data items. For facilities that have a registry it is permissible to change any data item, including the primary site and histology.

Follow Up Information

Additional follow-up information may be requested by the ACCR.

Non-Reportable File

All facilities with a registry are required to submit non-reportable cases to ACCR twice a year, January and October. These cases are to be documented and submitted electronically on an Excel spreadsheet. The following information must be included: Facility Name and Number, months/year being submitted, Patient Name (last and first), Social Security Number, Cancer Diagnosis (ICD-10 code), Cancer Site (ICD-O-3 code), Date of Birth, and Date of Diagnosis.

Data Transmissions

Security of Data Transmissions – Abstract data are to be transmitted using the Web Plus upload. Instructions for the use of Web Plus can be found on the ACCR utilities website (<https://adhcancer.arkansas.gov/>). **The ACCR requires that all data be submitted via Web Plus or ADH meaningful use ONLY. Pathology laboratories are required to submit data in HL-7 format through a secure portal approved by the ACCR.**

Protected Health Information (PHI) and other confidential data **MUST NOT** be included in e-mails to ACCR. Do not include information either in the text of the e-mail or as an attachment. If this happens, ACCR staff will alert the contact, so that the information can be deleted from all e-mail and report the event to the Arkansas Department of Health compliance officer.

Confidential information on individual cases may be uploaded using Web Plus non-NAACCR layout function.

Web Plus Software

Web Plus is a free, web-based application, developed by the CDC to provide a secure method of reporting cancer cases to the ACCR. For hospitals with their own stand-alone systems, Web Plus must be used to

upload bundled submissions of data in NAACCR XML format. Web Plus also provides an abstracting (or data entry) module for entering cancer cases for smaller facilities that do not have a registry.

Facilities using the abstracting modules will be setup on one of two different forms, the long form which is basically a full case abstract, and a short form which is more text-based entry. The ACCR will determine which form a facility will use. Training on using these forms will be provided by the ACCR. There is also training documentation available from the registry's utilities web site (<https://adhcancer.arkansas.gov/>).

Web Plus login page:

<https://adhcancer.arkansas.gov/WebPlus/logonen.aspx>

Meaningful Use

Meaningful use, or MU, is a federal initiative for the exchange of patient health care information between physicians and public health entities. The flow of data is an automated process of an EHR (electronic health record) being flagged and transmitted as an eligible record for exchange to the Arkansas Department of Health. Meaningful Use covers several areas such as immunizations and syndromic, cancer was added under phase II.

Under meaningful use, ambulatory facilities are eligible to send their cancer cases to the cancer registry via this exchange. The process involves registering with the ADH for intent to implement meaningful use; setting up a connection with the health department; testing the new stream of data over this connection; and finally into production (see the MU homepage at <http://www.healthy.arkansas.gov/programs-services/topics/meaningful-use>).

Once a facility is in production and the ACCR has verified the validity of this data, the facility can consider this method of reporting complete and are no longer required to report by other means such as Web Plus. If at any point the ACCR has determined this data to no longer be valid, however, the facility will be required to once again report in the conventional means described in this manual. A facility must be **validated and in production** to bypass the conventional reporting requirements, the testing phase does not fulfill these requirements.

IMPORTANT NOTE: Meaningful use under cancer is only applicable to ambulatory facilities. Hospitals are not eligible for this option of reporting. Also, due to initial testing and onboarding, the ACCR WILL NOT ACCEPT meaningful use data from ambulatory facilities with 50 or more cases annually or oncology centers of any annual caseload. These facilities must report using the conventional reporting requirements.

Chapter 2 – Determining Reportability

Case-Finding Techniques

Reportable Cases can be identified via many sources. The hospital pathology laboratory can provide cases diagnosed by histology, cytology, hematology, bone marrow or autopsy. Other sources are clinic admission logs, daily discharges, disease indices, inpatient and outpatient surgery logs, radiotherapy consults, treatment reports and logs, oncology clinic treatment reports and logs. *Never rely solely on the pathology department to provide reportable cases.* Doing so could exclude cases for which the hospital has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radiographically or clinically only without tissue confirmation would be missed during case-finding unless additional resources are employed. It is essential to include review of the Medical Record Disease Index (usually provided by Health Information Management) and other tracking tools such as medical and radiation oncology clinic logs to ensure that all reportable cases are identified. You should form an alliance with staff from the aforementioned departments to establish and develop a systemic method to routinely receive necessary information from them.

Reportable List for Case-Finding

The ACCR reportable list can be viewed/downloaded from the following address:

<https://adhcancer.arkansas.gov/Documents/ReportableList20-21.pdf>

Diagnoses are listed by ICD-10-CM codes which can be used by facilities to identify which cases to include on their MRDI case-finding lists. The list is updated annually to ensure that any new applicable codes are added.

Cases That Must Be Reported

Refer to the “ACCR Reportable List for Case-Finding” noted above when conducting case-finding activities. Depending on how case-finding is conducted, not all codes will be used by all facilities.

Malignancies with a behavior code (fifth digit of the morphology code) of 2 or 3 in ICD-O-3 (cases diagnosed on or after January 1, 2001) or the Hematopoietic Database Appendix D, except as otherwise noted in this manual

- Beginning with cases diagnosed on or after January 1, 2004, non-malignant primary intracranial and central nervous system tumors are required to be reported. See below for applicable site codes

Topography Codes for Intracranial and Central Nervous System Tumors

Codes	Description
C70.0-C70.9	Meninges
C71.0-C71.9	Brain
C72.0-C71.1	Spinal cord
C72.3-C72.5	Cranial nerves
C72.8-C72.9	Overlapping brain and CNS; CNS, NOS
C75.1	Pituitary gland
C75.2	Craniopharyngeal duct
C75.3	Pineal gland

- Beginning with cases diagnosed **on or after January 1, 2002**, the following squamous intraepithelial neoplasia, grade III (8077/2) are reportable (NPCR requirement)
 - AIN III (C21.1)

- VIN III (C51.*)
 - VAIN III (C52.*)
- For long term facilities (skilled nursing homes and hospices):
 - Any patient diagnosed with cancer prior to admission in your facility and undergoing cancer directed treatment.
 - Any patient diagnosed with cancer, but is being treated at your facility for other reasons (hip fracture, dementia, etc)
 - Any patient with a history of cancer who has been without disease for several months or several years, who is diagnosed and/or treated for recurrence of the original cancer.
- **Analytic cases-** Patients whose initial diagnosis was made at your facility and/or any part of the first course of treatment was delivered or prescribed at your facility (Class of Case: 00, 10, 11, 12, 13, 14, 20, 21, 22)
- Patients diagnosed at a staff physician's office and receiving any or their entire first course of treatment in your facility or a decision is made not to treat at facility. (Class of Case 12)
- **Nonanalytic cases-** Patients diagnosed elsewhere who had all first course treatment elsewhere who were seen at your facility for diagnosis of recurrent disease or for treatment of relapsed, persistent or progressive disease; cases diagnosed prior to the facility's Reference Date and diagnosis or treatment was given by the reporting facility. These cases are not required to be reported to ACCR. The following Nonanalytic cases **are reportable to ACCR**: specific squamous intraepithelial neoplasia, grade III (AINIII, VINIII, VAINIII); patient is diagnosed after January 1, 1996 (ACCR reference year); diagnosed at autopsy and not suspected prior to death (Class of Case 34, 35, 36, 37 and 38).
- Malignant tumors of the skin such as adnexal carcinoma/adenocarcinoma (8390/3-8420/3), lymphoma, melanoma, sarcoma, and Merkel cell carcinoma **must be reported**. Any carcinoma arising in a hemorrhoid is reportable, since hemorrhoids arise in mucosa, not in the skin.
- **All Gastrointestinal stromal tumors (GIST) are reportable as of January 1, 2021.** The behavior code is /3 in ICD-O-3.2. For GIST cases prior to 2021, if they are noted to have multiple foci, metastasis or positive lymph nodes or if the pathologist designates that they are malignant these are reportable and must be abstracted and assigned a behavior code /3.
- Carcinoid tumors of the appendix (C18.1) must be coded 8240/3 effective in 2015.
- Beginning January 1, 2021 Thyroid (C73.9) cases that are Non-invasive follicular thyroid neoplasm with papillary-like features (NIFTP) or Encapsulated follicular variant of papillary thyroid carcinoma, non-invasive (EFVPTC) are no longer reportable.
- Beginning January 1, 2021 primary sites of the skin (C44._) that are Dermatofibrosarcoma, NOS; Dermatofibrosarcoma protuberans, NOS; Pigmented dermatofibrosarcoma protuberans; Bednar tumor are no longer reportable.
- Beginning January 1, 2021, the following are reportable without the term "malignant" to be used in order to code behavior of /3: thymomas, insulinoma, glucagonoma, gastrinoma, VIPoma, somatostatinoma, paraganglioma, and pheochromocytoma.
- Beginning January 1, 2022 primary sites for stomach and small intestine (C160-C166, C168, C169, C170-C173, C178-C179) with Intestinal-type adenoma, high grade, Serrated dysplasia, high grade or Adenomatous polyp, high grade dysplasia is reportable.

Cases Not Required To Be Reported

- Skin cancers (C44.*) with histology codes 8000-8110 as of January 1, 2001

- Patients who have a history of cancer but diagnosis or treatment were not performed at your facility (Class of Case 33)
- Patients who receive transient care to avoid interruption of therapy started elsewhere (Class of Case 31)
- Patients seen only in consultation to confirm a diagnosis (Class of Case 30)
- Pathology cases that are consultative readings of slides submitted from outside facilities (Class of Case 43)
- Patients with adenocarcinoma in situ and carcinoma in situ of the cervix, cervical intraepithelial neoplasia (CIN) or prostatic intraepithelial neoplasia (PIN)
- Patients with a pre-cancerous condition or benign tumor (other than CNS sites stated above)
- Patients admitted to a hospice unit or home health care services

Note: Your cancer committee may decide to require additional benign or borderline cases. Please do not submit these reportable-by-agreement cases to the ACCR.

Ambiguous Terms at Diagnosis

Reportable cases are usually based on unequivocal statements made by recognized medical practitioners that the patient has a reportable diagnosis. However, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. In instances where pathology or cytology findings cannot definitively confirm a cancer diagnosis or when imaging studies show inconclusive results, physicians often state the diagnosis in ambiguous terms. The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to handle these situations is to follow up with the physician.

If the physician is not available, the medical record, and any other pertinent reports should be read closely for information and reportability of such a diagnosis depends on the verbiage used. **For a cancer case to be reportable, the ambiguous term must always include a reference to the reportable diagnosis being described, e.g., favors carcinoma or suspicious for malignancy. The purpose of the Ambiguous Terminology list in regards to determining reportability is to be used in cases where wording in the patient record is ambiguous and no further information is available from any resource.** When the diagnosis is stated in only ambiguous terms, use the following guidelines to determine whether a particular case should be reported.

Note: Synonyms of these terms do not constitute diagnosis.

Ambiguous terms that constitute a diagnosis

Apparent(ly)	Most likely	Appears
Presumed	Compatible with	Probable
Comparable with	Suspect(ed)	Suspicious (for)
Favors	Typical of	Malignant appearing
Consistent with		

Tumor* (beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)

Neoplasm* or Tumor (beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

Exception: If cytology is reported only using an ambiguous term (such as suspicious), do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Example: Discharge summary and X-ray results report “CT of the chest *compatible with* carcinoma of left lung.” Although there may be no further work-up or treatment, the case is radiographically diagnosed and **is reportable**.

Example: The only documentation says “likely” carcinoma. Because it does not say “most likely” it **is not reportable**.

Terms that DO NOT constitute a diagnosis**

Cannot be ruled out	Questionable	Equivocal
Rule out	Possible	Suggests
Potentially malignant	Worrisome	

**unless supplemented by additional information

Example: Barium Enema reveals a sigmoid mass *suspicious* for neoplasm. Colonoscopy reveals a sigmoid mass, “*possible* malignant neoplasm.” The patient is referred for biopsy and colon resection at another facility revealing carcinoma. The case is NOT reportable for your facility because mass and neoplasm are not associated with a reportable malignant term, whereas if it had been stated “suspicious sigmoid mass, *probable* malignant neoplasm,” it would be reportable.

Chapter 3 – Determining Primary Tumors

When potential cases are identified through the case-finding process, it is important to determine whether they represent new reportable primaries, or whether they are actually pointing to cases previously accessioned into the cancer registry database. The *Solid Tumor Rules* contains all rules for determining multiple primaries for solid tumors. These rules **MUST** be applied to all cases (except hematopoietic primaries) diagnosed January 1, 2018 (cases diagnosed January 1, 2007 – December 31, 2017 use the *Multiple Primary and Histology Rules*). For determining multiple primaries of hematopoietic origin diagnosed on or after January 1, 2010, refer to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic Database which can be found at <https://seer.cancer.gov/tools/heme/download>.

Multiple Primaries for Solid Tumors

Multiple primaries for solid tumors are determined according to the rules detailed in the *Multiple Primaries and Histology Coding Manual* (MP/H) for cases diagnosed **January 1, 2007 - December 31, 2017** and *Solid Tumor Rules* for cases diagnosed **January 1, 2018** and after. These manuals contain site-specific rules to apply in specific sequence for deciding whether multiple reportable primaries are present. Site-specific rules are subdivided into modules according to whether the case involves single or multiple tumors, or it is unknown whether multiple tumors are present in the primary site. **It is essential** to read the general instructions and the site-specific equivalent terms and definitions before using the site-specific coding rules.

Multiple Primary Rules for Hematopoietic Cases

Beginning with cases diagnosed January 1, 2010, multiple primaries for hematopoietic cases are determined according to rules set forth in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic Database which can be found at <https://seer.cancer.gov/tools/heme/>. Training modules are also available at this site and are highly recommended. The rules manual is navigated in a 5 step process:

1. Search the database for a provisional site and histology code
2. Use the Case Reportability Instructions to determine if the case is reportable
3. If so, go to the Multiple Primary Rules
4. Go to the Primary Site & Histology Rules (for every primary). Consult the database only when the rules specify to do so
5. Use the Grade of Tumor Rules

For hematopoietic cases diagnosed prior to 2010, use the tables in Appendix A of *FORDS* (<https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual>) to decide whether differing hematopoietic histologies represent one or more primaries. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

Chapter 4 – First Course of Therapy

Treatment or therapy for cancer is meant to modify, control, remove, or destroy cancer tissue (cancer-directed treatment). Therapy can be used to treat cancer tissue in primary or metastatic site(s), regardless of the patient's response to that treatment. The first course of therapy should include all cancer-directed treatments indicated in the initial treatment plan and delivered to the patient after initial diagnosis of cancer. Multiple modalities of treatment may be included and therapy of cancer-directed therapies proposed to eliminate or control the patient's disease. Treatment intentions may be found in discharge summaries, consultations, and outpatient records. All cancer-directed therapies (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy) documented in the physician's treatment plan and administered are included in the first course of therapy.

All Malignancies except Leukemia

The **first course of treatment** includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Treatment given specifically for tumor progression or recurrence, and treatment started when there is failure of the initial course of therapy are considered subsequent treatment.

Leukemia

The **first course of treatment** includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

Time Periods for First Course of Treatment (FCOT)

The **Date of First Course of Treatment** is earliest of Date of First Surgical Procedure, Date Radiation Started, Date Systemic Therapy Started, Date Other Treatment Started or the date the decision for no treatment was documented.

- **No Treatment:** is considered a treatment option and may represent the first course of therapy. Reason for no treatment should be entered in the appropriate treatment field.
- If there is no documented treatment plan and no other treatment guidelines are established, evaluate the therapy and the time it began in relation to the diagnosis date. If the therapy is a part of an established protocol or within accepted guidelines for the disease, consider it the first course of therapy.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle "initial treatment must begin within one year of the date of initial diagnosis"
- If FCOT systemic treatment regimen is changed due to an adverse reaction, follow these guidelines:
 - If the new chemotherapy drug(s) is in the same subcategory as the initial therapy (i.e. antimetabolite, alkylating agent, etc.) it is considered continuation of the first course of treatment. Some drugs overlap categories (alkaloid-antimetabolite) and are considered in the same category if either term matches the original sub-category.
 - If the drug(s) is not in the same group, it is no longer the first course of therapy
 - If the patient fails to respond to treatment and the regimen is changed, it is no longer first course of treatment. Lists of drugs and their classification(s) are available at <http://www.seer.cancer.gov/tools/seerrx/>

Example: Patient A is started on a planned course of Tamoxifen (anti-estrogen). It is effective, but she does not tolerate the drug side effects and is changed to Arimidex (aromatase inhibitor). This starts a new course of therapy because the two hormone drugs are not in the same subcategory.

Example: Patient B is started on Aromasin (aromatase inhibitor). It is effective but she is changed to Arimidex (aromatase inhibitor) for insurance reasons. That is still first course of therapy because both hormone drugs are in the same subcategory.

Example: Physician plans a combination regimen of chemotherapy. Velban (plant alkaloid) is one of the drugs, after several cycles, it is replaced with Oncovin (Plant alkaloid-antimetabolite) due to adverse reaction. This is still first course of therapy because both are in the same subcategory- alkaloid.

Example: Physician plans a regimen of Adriamycin (antitumor antibiotic)/Cytosan (alkylating agent). The patient does not respond so the treatment is changed to Methotrexate (antimetabolite)/5FU (antimetabolite). Because the initial treatment failed, the new chemotherapy regimen is coded as subsequent treatment.

Rx Summ – Treatment Status

Per STORE, this data item summarizes whether the patient received any treatment or if the tumor was under active surveillance. The item was added to document active surveillance (watchful waiting) and to eliminate searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Surgical Diagnostic and Staging Procedures (Non-Cancer Directed Surgery)

Surgical diagnostic and staging procedures such as biopsies, thoracentesis, and bypasses do not modify or destroy cancer cells. Surgical procedures that aspirate, biopsy or remove lymph nodes to diagnose and/or stage disease are to be entered in *Scope of Regional Lymph Node Surgery* not in this field.

Palliative Procedure

Procedures performed to palliate or alleviate symptoms may include surgery, radiation, systemic therapy and/or other pain management therapy. This data element allows the tracking of procedures that are considered palliative rather than therapeutic, diagnostic or used for staging. Examples of palliative procedures include: bypass/stent for pancreatic carcinoma; radiation for bone metastasis; palliative chemo for advanced lung cancer. Palliative treatments are to be coded in palliative procedure **and** First Course of Therapy. When palliative treatment is given as first course of therapy, the case is considered analytic. When palliative procedures do not remove, modify or destroy tissue (bypass stents, persistent pain management), the procedure is not treatment and is coded only if the case is otherwise reportable.

Note: Palliative radiation would be coded as '2' in Palliative Procedure field. The appropriate code would also be entered in the Radiation field.

Chapter 5 – Initial Abstract

In the chapters that follow, this manual lists standard field names. Please be aware that a given standard setter or software may display field names slightly different. Please see the STORE coding manual (https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2021.ashx) or the NAACCR data dictionary (<http://datadictionary.naacccr.org/>) for code lists and field information.

Reporting Hospital/Facility Number (Reporting Facility)

The number entered in this data field is used by the central registry to identify the facility reporting the case(s). The 10-digit institution number assigned by the Cancer Department of the American College of Surgeons (ACoS) must be right justified and preceded by zeros if less than 10 characters. For facilities with a 7-digit number (6-digit number preceded by a constant 6), this number would be right justified and preceded by 3 zeros. Some software can be programmed to auto-code this field. For facilities abstracting in WebPlus this information is auto-coded.

NPI – Reporting Facility

Enter the NPI number assigned to the facility identified above. The software vendor may have set this to code automatically.

Name – Last

Record the patient's last name. Mixed-case, embedded spaces, hyphens, and apostrophes are allowed.

Name – First

Record the patient's first name. Mixed-case and embedded spaces are allowed. Special characters are not allowed.

Name – Middle

Record the patient's middle name. Middle initial may be used if full middle name is not available. Leave blank if no middle name/initial is given. Mixed-case and embedded spaces are allowed; special characters are not.

Name – Alias

Many patients use a name different from their given name. If the patient uses an alias for the first name, record only the first name alias. If a patient uses an alias for the last name, record the last name alias. If a patient uses an alias for the first and last name, record both the last and first name alias. Do not use commas.

Name – Maiden

Record the maiden name of married female patients. If the patient has no maiden name or the information is not available, leave blank.

Patient Address and Residency Rules

The address at diagnosis can provide information to identify possible cancer clusters for environmental and epidemiological studies and provide essential information for public health activities.

The patient's address at diagnosis is the place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has multiple primary tumors, the address at diagnosis may be different for subsequent primaries.

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers being his or her usual home." Vital statistics rules may differ from Census rules. "Do not record the residence from the death certificate." Review each case carefully.

Record the patient's number and street address at the time the cancer was diagnosed or treated. Mixed case and embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs. Standard abbreviations may be used. If no street address is available, record "Unknown". **DO NOT LEAVE BLANK**

It may be necessary to use "Unknown" if the correct address at diagnosis is not known.

Do not update the address at diagnosis if the patient's address changes.

Rules for Persons with Ambiguous Residences

- Persons with more than one Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.
- Persons with no usual residence (transients, homeless): Use the address of the place the patient was staying when the cancer was diagnosed. This could be a shelter or a diagnosing facility.
- Persons away at school: College students are residents of the school area. Boarding school students below the college level are residents of their parents' homes.
- Persons away in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody," are residents of the institution. This includes the following:
 - Incarcerated persons
 - Persons in nursing, convalescent, and rest homes
 - Persons in homes, schools, hospitals, or wards for the physically disabled, mentally disabled, or mentally ill.
 - Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.
 - Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use the installation address or the surrounding community's address.

Address at Diagnosis – Supplemental

Record any additional address at diagnosis information such as name of nursing home or apartment complex.

Address at Diagnosis – City/Town

Record the city or town of the patient's address at the time of cancer diagnosis. If the city is unknown record UNKNOWN. **DO NOT LEAVE BLANK.**

If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.

Do not update this data item if the patient's city/town or residence changes.

State at Diagnosis

Record the U.S. postal service two-letter state abbreviation for the state of residence at cancer diagnosis. Use the two-letter abbreviation for patients whose residence at diagnosis was a Canadian province.

Use the following codes when the state or province is unknown or not applicable

- US = Resident of United States, NOS
- XX = Resident of country other than U.S. or Canada and the country is known
- YY = Resident of country other than U.S. or Canada and country is unknown
- ZZ = Resident of the U.S., NOS; Canada, NOS; residence unknown

Do not update this data item if the patient's state or residence changes.

Postal Code at Diagnosis

For U.S. residents record the 5-digit zip code and the 4-digit extension (if known) for the patient's address at diagnosis. For Canadian residents, use the 6-character alphanumeric postal code. Record 88888 8888 if the patient is a resident of a country other than Canada, U.S., or U.S. possessions and the postal code is not known. Record 99999 9999 if the patient is a resident of Canada, U.S., or U.S. possessions but the postal code is unknown or residence is unknown. Consult the zip code look up tool:

<https://tools.usps.com/go/ZipLookupAction!input.action>

County at Diagnosis

Code the county of the patient's residence at the time of diagnosis. For U.S. residents, standard codes are those of the FIPS publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas*. This publication can be accessed on the Internet at <https://www.census.gov/geo/reference/codes/cou.html>. If the patient has multiple tumors, the county codes may be different for each tumor.

Code 998 if known town, city, state, or country of residence, but county code not known and a resident outside of the state of the reporting institution (must meet all criteria).

Code 999 if the county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Address Current

Patient Address Current – Number and Street

City/Town Current

State – Current

Postal Code – Current (Zip Code)

These data items provide a current address, otherwise the rules for coding are as above.

Birth Date

Identifies the date of birth of the patient as indicated in the patient record.

For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.

Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely acceptable outside of the registry setting.

- The interoperable form of Date of Birth transmits in CCYYMMDD form where blank spaces are used unknown trailing portions of the date.
- If the year of birth is unknown, calculate the year.

EXAMPLE: The history and physical states that the patient is 75 years old at the time he is admitted into your facility, January 15, 2002. The patient is calculated to have been born in 1927. CCYY = 1927, MM = blank, DD = blank

- If month is unknown, the is coded unknown (left blank)
- If the year cannot be determined, the day and month are both coded unknown (left blank)
- If the date of birth cannot be determined at all the entire field is left blank. Record the reason in *Date of Birth Flag*.

Please see STORE 2018 Section Two: Coding Instructions – Patient Identification- Date of Birth

Date of Birth and Date of Birth Flag

This flag explains why there is no appropriate value in the corresponding date field, Date of Birth. As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding:

- Leave this item blank if Date of Birth has a full or partial date recorded
- Code 12 if the Date of Birth cannot be determined at all
- Registrars must enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software

Please see STORE 2018 Section Two: Coding Instructions – Patient Identification- Date of Birth

Social Security Number

Record the patient's Social Security number, if known, record without dashes.

Do not record the spouse's number. Code Social Security numbers that end with "B" or "D" as 999999999, the patient receives benefits under the spouse's number and this is the spouse's SSN.

Use 9s also if patient does not have a SSN or if SSN is not available.

Birth Place - State

This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers. This item was first defined for use in 2013; cases diagnosed before that date must be converted automatically by the registry's software from the former *Place of Birth*.

Alcohol History (state-specific field)

Code the patient's current or past usage of alcoholic beverages, such as wine or beer, using the codes:

CODE	DEFINITION
0	No history of alcohol usage
1	Current use of alcohol (this includes social usage)
2	Past history of alcohol usage, no current usage
9	Unknown (if no information is available)

Tobacco Use Smoking Status

As of January 1, 2022, CDC-NPCR is requiring the collection of a new data item called Tobacco Use Smoking Status (item #344). This is a tumor level variable that must be coded for 2022 diagnoses and forward. The purpose is to code the patient's current usage of tobacco (cigarette, cigar and/or pipe), using the codes:

CODE	DEFINITION
0	Never smoker
1	Current some day smoker
2	Former smoker
3	Smoker, current status unknown
9	Unknown if ever smoked

Tobacco History (state-specific field)

As of January 1, 2022, CDC-NPCR is requiring the collection of a new data item called Tobacco Use Smoking Status (item #344). The state-specific field Tobacco History (item #340), detailed here, is a patient level variable that is to be coded if the patient has a case prior to January 1, 2022. If the patient does not have a diagnosis prior to 2022 then this field can be left blank. Code the patient's current or past usage of tobacco products, using the codes:

CODE	DEFINITION
(BLANK)	Patient does not have a diagnosis prior to January 1, 2022
0	Never smoke
1	Cigarette smoker, current
2	Cigar/pipe smoker, current
3	Snuff, chew, smokeless tobacco, current
4	Combination use, current (Smokes and chews or dips)
5	Previous tobacco use
9	Unknown (no information available)

E-cigarettes *do not* qualify as tobacco use.

Family History (state-specific field)

Record any first-degree family (parents, brothers, sisters, and children) history of any reportable cancer.

Record in text any personal history of cancer for the patient that may be documented in the medical record.

CODE	DEFINITION
1	Yes
2	No
9	Unknown (if no information is available)

Race (1-5)

Race 1 identifies the primary race of the person and is the field used to compare with race data on cases diagnosed prior to January 1, 2000. This field allows calculation of race specific incidence rates. If only one race is reported for the person, use code '88' for remaining race fields (Race 2-5).

- If Race 1 is '99', Unknown, Race 2-5 must also be '99'
- This field is used to code the primary race of the person and is to be used in conjunction with "Spanish/Hispanic Origin". Additional races reported by the person must be coded in Race 2-5.
- Mexican, Puerto Rican or Cuban origins are coded as white.
- If a person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
- If a person is multiracial and one of the races is Hawaiian, code Hawaiian as Race 1 followed by the other race(s).

- A known race code (other than blank or 99) must not occur more than once. For example, do not code “Black” in Race 1 for one parent and “Black” in Race 2 for the other parent.
- If the case is diagnosed prior to 1/1/2000, Race 2-Race 5 must be blank, **UNLESS** the patient has more than one primary with at least one primary diagnosed 1/1/2000.
- If Race 2 is blank, Race 3 – Race 5 must also be blank.

Spanish/Hispanic Origin

This code identifies whether or not the person must be classified as “Hispanic”.

Sex

Code the patient’s sex.

Occupation Text

This data item is applicable for patients 14 years or older at the time of diagnosis and is reported in text only.

- Record the patient’s usual (longest held) occupation before the cancer diagnosis.
- If the patient had several jobs over a lifetime, record the occupation engaged in for the longest period of time, if known.
- If the patient is retired and the occupation is unknown, **DO NOT RECORD RETIRED**, record **UNKNOWN**.
- If the patient was a housewife/househusband and never worked outside of the home, record “homemaker”, “housewife” or “househusband”. (Industry: “own home”)
- Record “unknown” if no information is available. **DO NOT LEAVE BLANK**.

Industry Text

This data item is applicable for patients 14 years or older at the time of cancer diagnosis and is reported in text only.

- Record the primary type of business activity performed by the company where the patient was employed for the most number of years.
- Distinguish whether the industry is involved in manufacturing, wholesale, retail or service, etc.
- If the primary activity is unknown, record the name of the company and city or town. The central registry may be able to determine the business activity performed.
- Record “unknown” if no information is available. **DO NOT LEAVE BLANK**.
- If the patient is retired and the type of industry is unknown, **DO NOT RECORD RETIRED**, record **UNKNOWN** in this field.

Primary Payer at Diagnosis

This identifies the patient’s primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Instructions for Coding:

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment
- Record the type of insurance reported on the patient’s admission page
- Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006
- If more than one payer or insurance carrier is listed on the patient’s admission page, record the first

- If the patient's payer or insurance carrier changes, do not change the initially recorded code

Date of First Contact

Record the date of the first inpatient or outpatient encounter at this facility for diagnosis of and/or first course treatment of a reportable tumor. This may be the date of an outpatient visit for a biopsy, x-ray, scan or laboratory test.

This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

Instructions for Coding:

- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.
- If autopsy only or death certificate only case, then the date of death is the date of first contact.
- Record the date as complete as possible. Leave any unknown portions of the date blank.
- For analytic cases (Class of Case 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the Class of Case that causes the case to be abstracted.

Class of Case

This data element is designed to separate the reporting registry's cancer cases into **analytic** and **nonanalytic** categories. The code structure for this item was revised in 2010. ACCR requires Class of Case 00, 10,11,12,13, 14, 20, 21, 22, 34, 35, 36, 37 and 38.

Instructions for Coding:

- Code the *Class of Case* that most precisely describes the patient's relationship to the facility
- Code **00** applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code *Class of Case* 10.
- It is possible that information for coding Class of Case will change during the patient's first course of care. If that occurs during the abstracting process, change the code accordingly as new information becomes available in the patient record or from other facilities.
- Document *Institution Referred To* for patients coded 00, 13 to establish that the patient went elsewhere for treatment. Document *Institution Referred from* for patients coded 20-22 to establish that patient came from elsewhere.
- A staff physician (codes 10-12) is a physician who is not employed by the reporting facility, but has routine practice privileges there.
- Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges that are described in codes 10-12 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility.
- If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physician involved are staff physicians or not, as with any other physician.

- “In-transit” care is given to a patient who is temporarily away from the patient’s usual practitioner for continuity of care. They are Class of Case 31 (not reportable to ACCR). Monitoring of **oral** medication started elsewhere is also Class of Case 31 (no reportable to ACCR). If the patient begins first course of radiation or chemotherapy **infusion** elsewhere and continues at the reporting facility, the case is not in-transit, the case is analytic (Class of Case 20) and reportable to ACCR.

DEFINITIONS:

Analytic Classes of Case

Initial diagnosis at reporting facility or staff physician’s office

Code	ACCR Status	Definition
00	Reportable	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Reportable	Initial diagnosis at the reporting facility or in a staff physician’s office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Reportable	Initial diagnosis in staff physician’s office AND part of first course treatment was done at the reporting facility
12	Reportable	Initial diagnosis in staff physician’s office AND all first course treatment or a decision not to treat was done at the reporting facility
13	Reportable	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility
14	Reportable	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility

Initial diagnosis elsewhere

Code	ACCR Status	Definition
20	Reportable	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Reportable	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility
22	Reportable	Initial diagnosis elsewhere AND all first course treatment was done at the reporting facility

Non-analytic Classes of Cases

Patient appears in person at reporting facility

Code	ACCR Status	Definition
30	Not Reportable	Initial diagnosis and all first course treatment elsewhere AND reporting facility
31	Not Reportable	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32	Not Reportable	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence
33	Not Reportable	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only

34	Reportable	Initial diagnosis AND part or all of first course treatment by reporting facility
35	Reportable	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility; if diagnosed on or after January 1, 1996 are reportable to ACCR
36	Reportable	Initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Reportable	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility; if diagnosed on or after January 1, 1996 are reportable to ACCR
38	Reportable	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
<i>Patient does not appear in person at reporting facility (could be reportable by agreement for your facility)</i>		
Code	ACCR Status	Definition
40	Not Reportable	Diagnosis AND all first course treatment given at the same staff physician's office
41	Not Reportable	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Not Reportable	Non-staff physician or other facility not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (ex: hospital abstracts cases from an independent radiation facility)
43	Not Reportable	Pathology or other lab specimens only
49	Not Reportable	Death certificate only
99	Not Reportable	Non-analytic case of unknown relationship to facility

Type of Reporting Source

Code the source of documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a path lab report review and all source documents used to abstract the case are from the physician's office, code this item 4). This data item is used by the central cancer registry to assist in the measurement of case reporting from all facilities.

NPI -Primary Surgeon

This identifies the physician who performed the most definitive surgical procedure.

Record the 10-digit NPI number for the physician who performed the most definitive surgical procedure.

- To determine the physician's NPI number, search <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
- NPI must be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- If the patient did not have surgery, NPI for the primary surgeon is unknown or not available. The physician who performed the surgical procedure was not a surgeon (general practitioner), leave code blank

NPI - Attending Physician (Managing Physician)

The managing physician is the doctor responsible for the overall management and care of the patient during the diagnosis and treatment of the reported cancer.

Use the 10-digit NPI number for the managing physician.

NPI for the managing physician is unknown, leave field blank

NPI - Following Physician (Follow-Up Physician)

Record the NPI for the physician currently responsible for the patient's medical care.

The following physician is the first contact for obtaining information on a patient's status and subsequent treatment.

Chapter 6 – Cancer Identification

Primary Site

The primary site is defined as the organ or site in which the cancer originated or began. A metastatic site indicates that the primary (originating) tumor has spread from the original site to other areas in the body. Cancer registries code only the primary site in this field, using the appropriate ICD-O manual, to determine the correct site code. Indications of metastatic sites are used in the registry for identifying the extent of the patient's disease and for staging purposes. Coding the primary site properly is very important, as many other field codes stem from it.

Code the primary site in this field, using the ICD-O-2 (cases diagnosed prior to January 1, 2001) or ICD-O-3 (cases diagnosed on or after January 1, 2001) manual to determine the correct site code and follow the instructions for coding.

Use current **Solid Tumor Rules** to determine the number of reportable primaries for solid tumors. Beginning with 2010 cases follow the instructions in **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for assigning site for lymphomas, leukemia and other hematopoietic neoplasms. This manual may be downloaded from the SEER website at <http://seer.cancer.gov/tools/heme/index.html>. To determine primary site codes for cases diagnosed prior to 2010, follow instructions for coding in ICD-O-3, pages 20-40 and SEER's *Abstracting and Coding Guide for Hematopoietic Diseases*.

It is important to identify the exact location of the primary (originating) tumor whenever possible, and to enter the most specific ICD-O topography code listed into Primary Site field. The most specific location of a tumor must be coded. The registrar must use all documents available in the medical record to determine the most specific site code, including the pathology reports, scans, X-rays, MRIs, etc. The following points are helpful to consider when coding this field:

- Enter the specific sub site whenever applicable
EXAMPLE: A patient is diagnosed by CT scan with *mass in head of pancreas consistent with carcinoma*, code to C25.0 instead of C25.9, pancreas NOS.
- When a primary site is overlapping into one or more sub-sites, code the .8 (overlapping lesion code). Overlapping applies to sites that are contiguous (adjacent) to one another.
EXAMPLE: Patient is diagnosed with colon cancer. The surgeon states that intraluminal tumor involved the colon from the cecum to mid-ascending colon. Code C18.8 rather than coding the site to either cecum or ascending colon.
- When the primary tumor is multifocal throughout an organ or when there is no information identifying the sub site from which the primary tumor arose, use the sub site code .9 to indicate the site, NOS.
EXAMPLE: The pathology from a mastectomy specimen shows diffuse, multifocal ductal carcinoma throughout the breast. Code C50.9
- When multiple tumor arising in different sub site of the same anatomic site are reported as a single primary and point of origin cannot be determined, code the last digit of the primary site to .9.
EXAMPLE: Patient has an infiltrating duct cancer in the UOQ (C50.4) of the right breast, and another infiltrating duct cancer in the LIQ (C50.5) of the same breast. Code the primary site as C50.9.
- If the primary site is documented as an "unknown primary", use code C80.9.
- Kaposi's Sarcoma is coded to the site in which it originates. Code to skin, NOS (C44.9) if the disease arises simultaneously in the skin and another site, AND the primary site is not identified.

Histologic Type

Histologic type refers to the **classification** of malignancy described in the pathology or cytology report. This describes the microscopic composition of cells and/or tissue for a specific primary site. The tumor type or histology is a basis for staging and determination of treatment options.

Record histology using the 4-digit morphology codes found in the appropriate references as shown in the following table. The first three digits of the histology code will indicate the cancer cell type.

Instructions for Coding:

- ICD-O-3 identifies the morphology codes with an “M” preceding the code number. Do **NOT** record the “M”.
- Review all pathology reports related to the case.
- Code the final pathologic diagnosis for solid tumors.
- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are not interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).

Malignant Solid Tumors

Diagnosed January 1, 2021 and after	#1 Solid Tumor Rules #2 ICD-O-3.2 Implementation Guide and Tables https://www.naaccr.org/icdo3/ #3 ICD-O-3
Diagnosed January 1, 2018- December 31,2020	#1 Solid Tumor Rules #2 Guidelines for ICD-O-3 Histology Code and Behavior Update (https://www.naaccr.org/icdo3/#1582820761130-74100b9f-e677) #3 ICD-O-3
Diagnosed January 1, 2007– December 31, 2017	#1 <i>Multiple Primaries and Histology Coding Manual</i> #2 ICD-O-3
Diagnosed January 1, 2001 – December 31, 2006	ICD-O-3
Diagnosed prior to 2001	ICD-O-2 (enter into historic ICD-O-2 field) AND ICD-O-3 (enter into ICD-O-3 histologic type field)

Benign/Borderline Intracranial and Other CNS Tumor

Diagnosed January 1, 2018 and after	#1 Solid Tumor Rules #2 ICD-O-3.2 Implementation Guide and Tables https://www.naaccr.org/icdo3/ #3 ICD-O-3
Diagnosed January 1, 2007- December 31, 2018	#1 <i>Multiple Primaries and Histology Coding Manual</i> #2 ICD-O-3
Diagnosed January 1, 2004 – December 31, 2006	ICD-O-3
Diagnosed prior to 2004	Not Reportable

Lymphoma, Leukemia and other Hematopoietic Malignancies

Diagnosed January 1, 2010 and after

Hematopoietic and Lymphoid Neoplasms Case Reportability and Coding Manual and the Hematopoietic Database

Diagnosed January 1, 2001 – December 31, 2009

ICD-O-3

Diagnosed prior to 2001

ICD-O-2 (enter into historic ICD-O-2 field) AND

ICD-O-3 (enter into ICD-O-3 histologic type field)

Further instructions and rules that clarify histology coding are found in the *Solid Tumor Rules* manual.

Behavior Code

The behavior code occupies the 5th digit of the morphology code. This component of the histologic code indicates the way in which the neoplasm will act or behave – malignant (3) or non-malignant (2). Only neoplasms with the behavior code of 0 (benign), 1 (borderline), 2 (in situ) or 3 (invasive) are to be reported to the Arkansas Central Cancer Registry. ACCR only requires primary sites to be collected and submitted. If the pathology report describes the cancer as metastatic, the registrar must be alerted that the primary site is not described on this report and must take steps to identify the primary site with a behavior code of 3. The hospital registry does **not** utilize behavior codes of 6 or 9.

The following terms are synonymous with behavior code 2 (in-situ) cancers:

- Adenocarcinoma in an adenomatous polyp with no invasion of stalk
- Clark's level 1 for melanoma (limited to epithelium)
- Comedocarcinoma, non-infiltrating (C50. *)
- Confined to epithelium
- Hutchinson's melanotic freckle, NOS (C44. *)
- Intracystic, non-infiltrating
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to but not including the basement membrane
- Lentigo maligna (C44. *)
- Lobular neoplasia
- Lobular, noninfiltrating (C50. *)
- Noninfiltrating
- Noninvasive
- No stromal involvement
- Papillary, noninfiltrating or intraductal
- Pre-cancerous melanosis (C44. *)
- Queyrat's erythroplasia (C60. *)

Behavior code is coded as malignant (3) if there is documentation of any invasion present.

Juvenile astrocytoma (9421/1) must be coded as 3 by agreement of North American registry standard-setters.

Grade of Differentiation

Beginning with cases diagnosed in 2018, the definition of grade has expanded, and classification of grade now varies by tumor site and/or histology. Use the Grade Coding Instructions and Tables (Grade Manual) for cases diagnosed **January 1, 2018** and after. These instructions reflect several important changes in the

collection of Grade data items, including the use of AJCC-recommended grade tables where applicable and the introduction of Clinical, Pathological, and Post Therapy Grade data items. It is imperative that registrars read and follow the general instructions and Grade Table instructions as found in the Grade Manual v2.1 (<https://apps.naaccr.org/ssdi/list/>).

Grade will now be collected in three different data items:

- Grade Clinical
 - Can **NOT** be blank
 - Assign the highest grade from the primary tumor during the clinical time frame (before any treatment)
 - Do not record grade from a metastatic site
- Grade Post Therapy Clin (yc)
 - **For cases diagnosed on or after January 1, 2021**
 - Cases diagnosed 2018-2020 leave field blank
 - Can be blank
 - No neoadjuvant therapy
 - Clinical or pathologic case only
 - Diagnosed prior to January 1, 2021
 - Assign the highest grade from the microscopically sampled primary tumor following neoadjuvant therapy or primary systemic/radiation therapy
- Grade Pathologic
 - Can **NOT** be blank
 - Recorded for cases where a surgical resection is performed without neoadjuvant therapy
 - Assign the highest grade from the primary tumor
 - If clinical grade is highest, code this for both clinical and pathologic grades
 - Pathologic time frame applied (time of diagnosis through first course surgery(ies))
- Grade Post Therapy Path (yp)
 - Can be blank
 - No neoadjuvant therapy
 - Clinical or pathologic case only
 - Assign the highest grade from the resected primary tumor after the completion of neoadjuvant therapy

These are coding instructions for cases **diagnosed 1/1/2014 - December 31, 2017**.

A. Hematopoietic and Lymphoid Neoplasms

Cell Indicators (Codes 5, 6, 7, 8, 9)

Cell indicator describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used **ONLY** for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual

2. Determine the cell indicator by applying the “Grade of Tumor Rules” within the current Hematopoietic and Lymphoid Neoplasm Manual to code the grade.

B. Solid Tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). These similarities/differences may be based on pattern (architecture), cytology nuclear features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade such as Fuhrman’s grade for kidneys. Most systems use a combination of pattern and cytologic and nuclear features.

Coding for Solid Tumors:

1. Systemic treatment and radiation can alter a tumor’s grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.
2. Code the grade from the primary tumor only.
 - a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
 - b. If primary site is unknown, code grade to 9.
3. Code the grade for specific histologic terms that imply a grade.

Carcinoma, undifferentiated (8020/34)
Follicular adenocarcinoma, well differentiated (8331/31)
4. In situ and/or combination in situ/invasive components:
 - a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.
 - b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.
5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
 - a. Special grade systems for the sites listed in Coding for Solid Tumors #6
 - b. Differentiation: use Coding for Solid Tumors #7: 2, 3, or 4 grade system
 - c. Nuclear Grade: use Coding for Solid Tumors #7: 2, 3, or 4 grade system
 - d. If it isn’t clear whether it is a differentiation or nuclear grade and a 2, 3, or 4 grade system was used, code it.
 - e. Terminology (use Coding for Solid Tumors #8)
6. Use the information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.

Special grade systems for solid tumors

Based on CS Site-Specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade. Do NOT use for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis) or FIGO (female gynecologic sites) grades.

7. Use the Two-, Three-, or Four-grade system information

a. Two-grade system

Term	Description	Grade Code
1/2, I/II	Low Grade	2
2/2, II/II	High Grade	4

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system

b. Three-grade system

Term	Description	Grade Code
1/3	Low Grade	2
2/3	Intermediate Grade	3
3/3	High Grade	4

c. Four-grade system

Term	Description	Grade Code
1/4	Grade 1; Well Differentiated	1
2/4	Grade 2; Moderately Differentiated	2
3/4	Grade 3; Poorly Differentiated	3
4/4	Grade 4; Undifferentiated	4

8. Terminology: use the 'Description' column or 'Grade' column to code grade. Breast & Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception Breast/Prostate code
Differentiated, NOS	I	1	
Well Differentiated	I	1	
Stated 'Grade 1'	I	1	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Moderately differentiation	II	2	
Moderately well differentiated	II	2	
Stated 'Grade II'	II	2	

Moderately Poorly differentiated	III	3	
Poorly differentiated	III	3	
Dedifferentiated	III	3	
Stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Stated as 'Grade IV'	4	4	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown)

C. Special Grade Systems Rules

Breast (exclude lymphomas)

- Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as state below.
- Code the tumor grade using the following priority order:
- BR Scores 3-9
- BR Grade (low, intermediate, high)
- If only a grade of 1-4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "Coding for Solid Tumors" #7 above.
- Code the highest score if multiple scores are reported.

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, BR grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Kidney Parenchyma (exclude lymphomas)

- The Fuhrman Nuclear Grade must be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below.
- Do NOT use for kidney renal pelvis.
- If your registry does not collect this SSF, use the description in the table to determine grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

Soft Tissue: Grade for Sarcomas (excluding lymphomas)

- The grade for sarcomas must be used to code grade based on CSv2 SSF1 as stated below.
- If your registry does not collect this SSF, use the description in the table to determine grade.
- The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.
- Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as “well differentiated” or “poorly differentiated”, go to Coding for Solid Tumors #8.
- In some cases, especially for needle biopsies, grade may be specified only as “low grade” or “high grade”. The numeric grade takes precedence over “low grade” or “high grade”.

Description	CS Code	Grade Code
Specified as Grade 1 (of 3)	010	2
Specified as Grade 2 (of 3)	020	3
Specified as Grade 3 (of 3)	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (excluding lymphomas)

- Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy.
- Exclude results from tests performed after neoadjuvant therapy began.
- This information is collected in CSv2 SSF 8 and SSF 10 as stated below.
- Usually prostatic cancers are graded using Gleason score or pattern. Prostatic cancer generally shows two main histologic patterns. The primary pattern, pattern occupying greater than 50%

of the cancer, is usually indicated by the first number of the Gleason grade. The secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10.

- If there are two numbers, assume that they refer to two patterns and sum them to obtain the score.
- If only one number is given and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade.
- If only one number is given and it is greater than 5, assume that it is a score and use it.
- If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: Pathology report says Gleason 3/10. The Gleason score would be 3.

Gleason Score	CS Code	Grade Code	AJCC 7 th	SEER 2003-2013	AJCC 6 th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5*	005	1	G1	G2	G2	G2
6*	006	1	G1	G2	G2	G2
7*	007	2	G2	G3	G3	G3
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

*The relationship in Gleason score to grade changes for 1/1/2014 and forward diagnoses in order to have the grade field in sync with AJCC 7th edition. Analysis of prostate grade before 2014 based solely on grade is not recommended.

**Please refer to *FORDS 2015*-Section One: Case Eligibility and Coding Principles, Cancer Identification, Coding Grade for full instructions on coding grade.

Date of Diagnosis

Record the month, day, and year this cancer was originally diagnosed by a medical practitioner. This date must reflect the first clinical onset of disease and may not be histologically confirmed. This date must not be changed, even if the disease is histologically confirmed later.

Example: Patient has a diagnostic ultrasound on June 6, 2010 that is highly suspicious for malignancy. On June 30, 2010 a biopsy is performed and results show invasive ductal carcinoma. Date of diagnosis is 06/06/2010 (CCYY=2010, MM=06, DD=06)

- Backdating- If a non-diagnostic workup was performed on a patient but at a later date malignancy is confirmed and the physician specifically states that in retrospect the patient had cancer earlier backdate the date of diagnosis to reflect the earlier date. This also includes pathology that may have been diagnostic but upon further review of the specimen it is now thought to have been malignant. However, the abstractor must carefully review the additional information before making the change.

Refer to the list of “Ambiguous Terms” in Chapter 2 for terminology that constitutes a diagnosis of cancer.

- Record the date as completely as possible. Leave any unknown portions of the date blank. **Example:** The patient was admitted to your facility in June of 2010 for seed implant radiation for prostate cancer diagnosed elsewhere approximately 4 months earlier, exact date unknown. Date of Diagnosis: 02/___/2010 (CCYY= 2010, MM= 02, DD= blank)
- If the cancer was first diagnosed at autopsy, the date of diagnosis is the date of death.
- If only the time of year (spring, middle, fall, or winter) is documented use April, July, October, and either December (if end of year) or January (if beginning of year) respectively.
- Year of diagnosis cannot be blank for analytic cases. If year of diagnosis is not known, it must be approximated for all cases as follows (and noted in a text field as estimated):
 1. If you know there was treatment before the patient arrived at the hospital, try to determine whether that was “this year” or “last year”, based on the current time of year and whether the treatment was likely days, weeks, or months ago.
 2. **Example:** The patient was admitted for initial chemotherapy on January 2 after recovering from surgery. Enter the preceding year as the diagnosis date.
 3. Code a “couple of years” to two years earlier
 4. Code a “few years: to three years earlier
 5. Code “several” to four years earlier
 6. Use whatever information is available to calculate the year of diagnosis.
 7. If no information about the date of diagnosis is available:
 - a. Analytic Cases:
 - Use the date of admission as the date of diagnosis
 - In the absence of an admission date, code the date of first treatment as the date of diagnosis
 - Please note in a text field that no information was available
 - b. Non-Analytic Cases:
 - When no information is available to approximate a year of diagnosis for non-analytic cases, the field may be left blank.

Date of Diagnosis Flag

This flag explains why no appropriate value is in the field, Date of Diagnosis.

Code	Description
12	A proper value is applicable but not known (e.g. date of diagnosis is unknown)
Blank	A valid date is provided in item Date of Diagnosis

Diagnostic Confirmation

Information for this field records the best method of how the reported cancer was diagnosed at any time in the patient’s history.

The data item represents a hierarchical coding scheme with code 1 taking precedence.

If any time during the patient’s cancer experience, a more definitive diagnostic method is performed and confirms a malignancy; this data item must be changed to reflect that confirmation.

Example: Patient is diagnosed on 2/10/10, by CT scan with probable lung cancer with no further workup. Diagnostic confirmation is coded to radiology (7). Later in March of 2010, the patient undergoes a bronchoscopy in which biopsies confirm squamous cell carcinoma. The diagnostic confirmation code is changed to reflect the positive histology (1).

Instruction for Coding Solid Tumors:

- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage. Bone marrow biopsy and bone marrow aspiration.
- Assign code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as fine-needle aspiration (FNA), sputum smears, cervical smears, vaginal smears, bronchial brushings and washings, tracheal washings, Prostatic secretions, breast secretions, gastric fluids, spinal fluid, peritoneal fluid, pleural fluid and urinary sediment – includes paraffin-block specimens from concentrate spinal, pleural, or peritoneal fluid
- Assign code 4 when the case is reported as microscopically confirmed, but no information is available about the method (histology or cytology)
- Assign code 5 when the diagnosis of cancer is based on certain laboratory tests or marker studies clinically diagnostic (abnormal electrophoretic spike for multiple myeloma or Waldenstrom's macroglobulemia, alpha -fetoprotein for liver cancer) for that specific cancer.
- Assign code 6 when the diagnosis is based on the surgeon's operative report from a surgical exploration or by endoscopy in the absence of tissue or cytologic findings. Autopsy only case (information from gross autopsy report)
- Assign code 7 when the diagnosis is based on the report by the physician from an imaging technique only, includes ultrasound, computerized (axial) tomography (CT or CAT) and magnetic resonance imaging (MRI) – no positive histology or cytology
- Assign code 8 when the case was diagnosed by any clinical method not mentioned above – no positive histology or cytology. Reported by the physician in the medical record.
- Assign code 9 when there is a statement of malignancy reported in the medical record– method of confirmation is unknown

Microscopic Confirmation for Solid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; cells microscopically examined)
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory test/marker studies which are clinically diagnostic for cancer. Elevated PSA is NOT diagnostic of cancer. If the physician used the PSA as the basis of diagnosing prostate cancer with NO other work up, record code 5.

6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from imaging technique only
8	Clinical diagnosis only, other than 5, 6, or 7	The malignancy was reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed

Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9992)

There is no priority hierarchy for coding Diagnostic Confirmation for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database* for information on the definitive diagnostic confirmation for specific types of tumors.

- Use code 1 when **ONLY** the tissue, bone marrow, or blood was used to diagnose the specific histology. Do not use code 1 if the provisional diagnosis was based on tissue, bone marrow, or blood and the immunophenotyping or genetic testing on that same tissue, bone marrow, or blood identified the specific disease (see code 3).
- For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow or blood.
- Use code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal pleural or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Assign code 3 when there is a histology positive for cancer **AND** positive immunophenotyping and/or genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010. **Example:** bone marrow exam is positive for acute myeloid leukemia (9861/3) Genetic testing shows AML with invasion (16) (p13.1q22) (9871/3).
- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.
- Assign code 8 when the case was diagnosed by any clinical method not mentioned in a preceding code. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Codes for Hematopoietic and Lymphoid Neoplasms

Code	Label	Definition
1	Positive histology	Histologic confirmation

2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; cells microscopically examined)
3	Positive histology PLUS positive immunophenotyping AND/OR positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory test/marker studies which are clinically diagnostic for cancer. Elevated PSA is NOT diagnostic of cancer. If the physician used the PSA as the basis of diagnosing prostate cancer with NO other work up, record code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from imaging technique only
8	Clinical diagnosis only, other than 5, 6, or 7	The malignancy was reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed

Laterality

Laterality identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only. Laterality supplements staging and extent of disease information and defines the number of primaries involved.

Instructions for Coding

- Code laterality for all paired sites; see *Solid Tumor Rules* for lists of paired organs in the corresponding site-specific table(s)
- Do not code metastatic sites as bilateral involvement
- Where the right and left sides of a paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Most paired sites cannot develop midline tumors (such as breast) because the right and left organs do not touch. Skin of the trunk is an example of a site where midline coding is possible.
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites to 0.
- If both lungs have nodules or tumors and lung of origin is not known, assign code 4

Chapter 7 – Staging Schemes

SEER Summary Stage

SEER Summary Stage was previously required for cases diagnosed in 2001-2003. SEER Summary Stage 2000 is required again for cases diagnosed in 2015 - 2017. SEER Summary 2018 is for cases diagnosed 2018 and forward. For all other years, vendors have been instructed to transmit this field as blank. For instructions see the SEER Summary Staging Manual 2018 v2.1 at <https://seer.cancer.gov/tools/ssm/>. Pages 9-28 provide important introductory material and are followed by site-specific chapters.

SEER Extent of Disease (EOD)

SEER EOD is required for cases diagnosed in 2018 and forward. It applies to every site/histology, including lymphomas and leukemias. Follow the instructions and guidelines as found in the SEER EOD 2018 manual at <https://seer.cancer.gov/tools/staging/eod/>. Beginning in January 1, 2022 use the SEER EOD v2.1, see change log at <https://seer.cancer.gov/tools/staging/eod/change-log.pdf>.

AJCC Stage

For cases diagnosed **January 1, 2018** and after only American College of Surgeons Commission on Cancer (CoC) accredited facilities are required to submit AJCC TNM staging using the AJCC TNM 8th edition.

AJCC staging **is required** for all facilities for cases diagnosed 2015 - 2017. Fields include clinical and pathologic T, N and M elements as well as Group, Descriptor and TNM Edition Number. Please refer to FORDS 2015 <https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual> and the AJCC Cancer Staging Manual, 7th Edition. AJCC training materials can be accessed at <https://cancerstaging.org/CSE/Registrar/Pages/default.aspx>.

Please refer to the appropriate staging manual for cases diagnosed prior to January 1, 2004

NOTE: *AJCC Manual for Staging Cancer*, Third Edition used with cases diagnosed 1989-1992
AJCC Manual for Staging Cancer, Fourth Edition used with cases diagnosed 1993-1997
AJCC Manual for Staging Cancer, Fifth Edition used with cases diagnosed 1998-2002
AJCC Manual for Staging Cancer, Sixth Edition used with cases diagnosed 2003-2009
AJCC Manual for Staging Cancer, Seventh Edition used with cases diagnosed 2010 forward

Collaborative Staging

Collaborative Staging will be used for cases diagnosed on or after January 1, 2004 thru 2015 diagnoses.

Collaborative staging is optional for 2016 and 2017 diagnoses and must be left blank for 2018+ diagnoses.

Current Collaborative Staging Version, 02.05, will be used for all applicable cases. The Collaborative Staging System schemas consist of the data fields necessary to derive T, N, M, and Stage Group according to the sixth and seventh editions of the AJCC Staging Manual; Summary Stage 1977, and SEER Summary Stage 2000.

- Collaborative Staging is collected on all cases diagnosed on or after January 1, 2004 regardless of whether they are microscopically confirmed.
- Collaborative Staging is collected on all sites/histologies.
- All schemas apply to all histologies unless otherwise noted.

For more information on collaborative staging please refer to the online manuals at <https://cancerstaging.org/cstage/schema/Pages/version0205.aspx>.

REFER TO THE APPROPRIATE MANUAL WHEN STAGING. NEVER RELY ON YOUR MEMORY.

Site-Specific Data Items (SSDI)

In 2018, Collaborative Stage (CS) Site-Specific Factors (SSF) will be discontinued and Site-Specific Data Items (SSDIs) will be used for collection of site-specific information. SSDI's will have unique names and NAACCR data item numbers, and can be applied to as many sites as needed. Field length is not limited to 3 digits, decimals are allowed, and different coding conventions are used to record actual values, percentages and ranges. Refer to the SSDI Manual for all guidelines and instructions (<https://apps.naaccr.org/ssdi/list/>). Beginning with **cases diagnosed on January 1, 2022** and forward use SSDI Manual v2.1.

Regional Nodes Positive

Record the exact number of regional lymph nodes examined by the pathologist and found to contain metastasis. Note: distant lymph nodes are coded in the "CS Mets at DX" field. Refer to the current **STORE** manual for complete directions.

Regional Nodes Examined

Record the total number of regional lymph nodes that were removed and examined by the pathologist. Refer to the current **STORE** manual for complete directions.

Date Regional Lymph Node Dissection (LND)

This is a required data item for cases diagnosed **January 1, 2018** and after. Record the date of regional lymph node dissection. If a sentinel lymph node biopsy is performed at the same time as a regional lymph node dissection record the date in both data items (Date of Sentinel Lymph Node and Date of Regional Lymph Node Dissection). Do not record the date of lymph node aspiration, core needle biopsy, or anything less than a regional lymph node dissection. For complete instructions see the current **STORE** manual.

Sentinel Lymph Nodes (SLN) Positive

This data item is **required for breast and cutaneous melanoma cases only**. Record the number of positive SLN during a sentinel node biopsy procedure. **FOR BREAST ONLY:** if a SLN biopsy is performed during the same procedure the regional node dissection use code 97 in this data item. For complete instructions see the current **STORE** manual.

Sentinel Lymph Nodes (SLN) Examined

This data item is **required for breast and cutaneous melanoma cases only**. Record the total number of lymph nodes examined during a sentinel node biopsy procedure. For complete instructions see the current **STORE** manual.

Date of Sentinel Lymph Node Biopsy

This data item is **required for breast and cutaneous melanoma cases only**. Record the date of the sentinel lymph node biopsy procedure. Do not record the date of lymph node aspiration, core needle biopsy or core biopsy. For complete instructions see the current **STORE** manual.

Surgical Diagnostic and Staging Procedure (RX Summ-DX/Stg Proc)

Identifies the positive surgical procedure(s) performed in an effort to diagnose and/or stage disease. This data item is used to track the use of surgical procedure resources that are not considered treatment. For complete instructions for coding see the current **STORE** manual.

Instructions for Coding:

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility
- Only record positive procedures. For benign and borderline reportable tumors, report biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy or primary site)
- If a lymph node is biopsied or removed to diagnose or stage **lymphoma** and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma use the data item *Surgical Procedure of Primary Site* to code these procedures.
- Do **not** code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* to code these procedures.
- Do **not** code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* to code these procedures.

Date of Surgical, Diagnostic and Staging Procedure (RX Date-DX/Stg/Proc)

This data item records the date on which the surgical diagnostic and/or staging procedure was performed and is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions:

- Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* was performed at this or any facility
- Record the date as completely as possible. Leave any unknown portions of the date blank.
- If information for this item is entirely unknown or not applicable, leave the field blank and complete the *RX Date-DX/Stg/Proc Flag* field

Rx Date-DX/Stg/Proc Flag

This flag explains why there is not appropriate value in the corresponding date field, *Date of Surgical Diagnostic and Staging Procedure*.

Chapter 8 – Tumor Directed Treatment

Record all first course of treatment (FCOT) cancer-directed therapy information available whether administered at the reporting hospital or at another facility. If the patient receives part of the FCOT at the reporting hospital and is transferred to another facility to continue treatment, also record the treatment given at the other hospital, if it is known. Documenting all treatments in the given RX Summ fields provides a complete “picture” of the patient’s cancer experience and is meaningful in calculating survival statistics and assessing treatment success. Subsequent courses of treatment must only be mentioned in text fields. Refer to the current **STORE** manual for complete coding instructions.

Date of First Course Treatment (Date of 1st Crs RX-CoC)

Record the earliest date on which treatment (surgery, radiation, systemic or other therapy) for the reported cancer began, including active surveillance only, whether administered at the reporting hospital or at another facility.

Instructions for Coding:

- Record the date as completely as possible. Leave any unknown portions of the date blank. **Example:** Patient came to your facility for chemotherapy in March of 2010 after having had surgery in February of 2010, exact day unknown. 02/___/2010 (CCYY=2010, MM=02, DD=blank)
- If active surveillance or watchful waiting is selected as the first course of treatment, record the date this decision is made.
- In case of non-treatment in which a physician decides not to treat a patient or a patient’s family or guardian declines all treatment, record the date this decision was made as first course of treatment
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that
- If the patient expired before planned treatment could begin, enter the date of death

Date of First Course Treatment Flag

This flag explains why there is no appropriate value in the corresponding date field, Date of First Course of Treatment. Refer to *STORE Section two, Coding Instructions* for instructions to code this item.

Rx Summ – Treatment Status

This data item summarizes whether the patient received any treatment, including watchful waiting. This item was added to document active surveillance and eliminate searching each treatment modality in order to determine whether any treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date.

Instructions for Coding:

- This item may be left blank for cases diagnosed prior to 2010
- Treatment given after a period of active surveillance is considered subsequent treatment and if not coded in this item
- Use code 0 when treatment is refused or the physician decides not to treat for any reason, including co-morbidities

Date of First Surgical Procedure

Formerly called Date of Cancer-Directed Surgery.

This data item records the earliest date on which any first course surgical procedure was performed and can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Instructions for Coding:

- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery* (excludes code 1) or *Surgical Procedure/Other Site* performed for this cancer.
- A needle biopsy is not considered to be an excision and therefore not a primary breast surgery. The date it was performed is not entered as the Date of First Surgical Procedure. It is now only entered in Date of Surgical, Diagnostic and Staging Procedure.
- If a biopsy of the primary site (excluding needle biopsy) is the initial surgical procedure and leaves only microscopic residual tumor, code the date of the biopsy in this field.
- **Example:** An excisional biopsy of a right forearm lesion done on 4/15/10 showed a Clark level II melanoma extending to the deep margin. Re-excision on 4/22/10 did not show any residual tumor. Code the Date of First Surgical Procedure as 4/15/10.

RX Date – Surgery Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical procedure*. Registries must enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Refer to *STORE Manual, Section Two: Coding Instructions* for further instructions

Date of Most Definitive Surgery

This field records the date of the most definitive surgical procedure of the primary site performed as part of the first course of treatment. Record the date on which the surgery described by *Surgical Procedure of Primary Site* was performed at this or any facility.

RX Date – Most Definitive Surgery Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date of Most Definitive Surgical Resection of the Primary Site*.

Surgical Procedure of Primary Site

This data item records the surgical procedure(s) performed to the primary site.

Instructions for Coding:

- Site-specific codes for this data item are found in *Appendix A* of *STORE* manual.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows for multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.

- If a needle biopsy preceded an excisional biopsy or more extensive surgery even if no tumor remained at the time of surgery both the needle biopsy (*Surgical Diagnostic and Staging Procedure*) and the *Surgical Procedure of the Primary Site* are to be reported. Surgical margins must be examined to determine whether a biopsy intended as incisional is excisional instead, and margins cannot be evaluated for a needle biopsy.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix A.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. Do not rely on registry software to perform this task for you.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care

Reason for No Surgery of Primary Site

This field records the reason that no surgery was performed on the primary site. This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Instructions for Coding:

- If *Surgical Procedure of Primary Site* is coded 00, then record the reason based on documentation in the patient record
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient
- Code 1 if *Surgical Procedure of Primary Site* is coded 98
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed
- Cases coded 8 can be followed and updated to a more definitive code as appropriate
- Code 9 if the treatment plan offered multiple choices, but is unknown which treatment, if any was provided

Surgical Margins of the Primary Site

This data item records the final status of the surgical margins after resection of the primary tumor.

Instructions for Coding:

- Code the margin status as it appears in the pathology report after the resection of the primary tumor.
- Microscopic involvement is **not** visible to the eye and is usually documented in the final diagnosis or microscopic portion of the pathology report.
- Macroscopic is visible to the eye and is documented in the operative report or the gross portion of the pathology report.
- Codes 0-3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- If no surgery of the primary site was performed, code 8
- If the pathology report makes no mention of margins, code 9

- For lymphomas (M-9590-9726, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0-C77.9), code 9.

Example: Patient has Excisional biopsy with involved margins. Later has a modified radical mastectomy with clear margins. Code the margin status after the mastectomy, 0-All margins grossly and microscopically negative.

Scope of Regional Lymph Node Surgery

This field identifies the removal, biopsy or aspiration of regional lymph node(s) at the time of the surgery of primary site or during a separate surgical event.

There is no minimum number of lymph nodes removed in order to record this field. If only one lymph node was removed, code using the range of 1-5.

Instructions for Coding:

- The scope of regional lymph node surgery is collected for each surgical event even if the surgery of the primary site was not performed.
- Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- Code 9 for any schema ID with primary site: C420, C421, C423, C424, C700-C709, C710-C729, C751-C752, C761-C768, C770-C779, C809; Lymphoma (excluding CLL/SLL, Schema ID 00790); Lymphoma (CLL/SLL, Schema ID 00795); Plasmacytoma, bone (9731/3).
- Do not record distant lymph node removal in this field. Code in Surgical Procedure/Other Site. If still unable to determine whether it is regional perform an internet search or review anatomy text books to find synonyms of the lymph node.
- Refer to current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong patient's life for by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care

See general instructions applying to all sites and additional notes specific to breast, *STORE Section Two, Coding Instructions*

Surgical Procedure/Other Site

Record the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

- If other tissues or organs are removed during primary site surgery that are not specifically defined by the site-specific Surgical Procedure of the Primary Site code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Incidental removal of tissue or organs is **not** a "Surgical Procedure/Other Site."
- Surgical Procedure/Other Site is collected for each surgical event even if surgery of the primary site was not performed

Radiation Data Items

The way radiation data items are recorded changed in 2018. These changes included new radiation data items. The following is not a full nor complete listing of all radiation data items. The ACCR requires that all facilities submitted the NPCR-CDC required data items. See the current *STORE* manual for complete coding

instructions and the CTR Guide to Coding Radiation Therapy in the STORE, https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx.

Date Radiation Started

This field records the date on which radiation therapy began at any facility that is part of the first course of treatment. It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some disease, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathologic stage information.

Instructions for Coding:

- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started must be the same as the date entered into the item Date of First Course Treatment.
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment
- Record the date as completely as possible. Leave any unknown portions of the date blank.

RX Date – Radiation Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started*. Registrars must enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Phase 1 Radiation Modality

This reflects whether the treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. Record the type of treatment administered as FCOT during phase 1.

Note: Do not confuse a diagnostic **radioiodine scan** with treatment. Only treatment is recorded in this item.

Radiation/Surgery Sequence

This data item records the sequencing of radiation and surgical procedures given as part of the first course of treatment

Instructions for Coding:

- Surgical procedures include *Surgical Procedure of Primary Site*, *Scope of Regional Lymph Node Surgery* (excludes code 1), *Surgical Procedure/Other Site*. If all of these procedures are coded 0, or it is not known whether the patient received both surgery and radiation, then this item must be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Regional Lymph Node Surgery*, or *Surgical Procedure of Other Site*, then code this item 2-9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Refer to *STORE Section Two*, Coding Instructions for complete instructions/First course of treatment.

Chemotherapy

Records the type of chemotherapy administered as FCOT at this and all other facilities. If not administered, then this item records the reason it was not performed. This may involve the administration of one or a

combination of chemotherapeutic drugs. Refer to *STORE Section Two, Coding Instructions* for complete instructions.

Refer to the SEER Rx Interactive Drug Database, <https://seer.cancer.gov/seertools/seerrx/> for a list of chemotherapeutic agents.

Date Chemotherapy Started

Record the date initiation of chemotherapy that is part of the first course of treatment. **RX Date-Chemo Flag** explains why there is no appropriate value in the corresponding date field, Date Chemotherapy Started.

Refer to *STORE Section Two, Coding Instructions* for complete instructions/*First Course of Treatment*

Hormone Therapy (Hormone/Steroid)

This data item records the type of hormone therapy administered as first course treatment at this and all other facilities. This therapy is defined as any agent (drug) and/or procedure that affect cancer tissue by changing the hormonal balance of the patient. Included are hormones, anti-hormones and steroids. It is not usually used as a curative measure.

Instructions for Coding:

- Record prednisone as hormonal therapy when administered in combination with chemotherapy such as MOPP or COPP
- Do not code prednisone as hormonal therapy when it is administered for reasons other than chemotherapeutic treatment
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

Refer to the *SEER Rx Interactive Drug Database* (<http://www.seer.cancer.gov/>) for a list of hormonal agents.

Date Hormone Therapy Started

This field records the date the hormonal therapy that is part of the first course of treatment. **RX Date-Hormone Flag**, this flag explains why there is no appropriate value in the corresponding date field, Date Hormone Therapy Started.

Refer to *STORE Section Two, Coding Instructions* for complete instructions

Immunotherapy (BRM)

Records the type of immunotherapy administered as first course treatment in this or any other facilities. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Refer to the *SEER Rx Interactive Drug Database* (<http://www.seer.cancer.gov/>) for a list of hormonal agents.

Date Immunotherapy Started

Record the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment. **RX Date-BRM Flag**, this flag explains why there is no appropriate value in the corresponding date field, Date Immunotherapy Started.

Refer to *STORE Section Two, Coding Instructions* for complete instructions

Hematologic Transplant and Endocrine Procedures

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. This field allows for the coding of treatment that involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents. Procedures coded in this field include bone marrow transplants, stem cell harvests, and endocrine surgery and/or radiation.

Instructions for Coding:

- Bone marrow transplants must be coded as autologous (bone marrow from patient) or allogeneic (bone marrow donated from family member). Syngeneic transplants (marrow from identical twin) are coded as allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery as procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

Refer to *STORE Section Two*, Coding Instructions for complete instructions

Other Treatment

This field identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding:

- The principal treatment for certain reportable hematopoietic disease could be supportive care that does not meet the usual definition of treatment that “modifies, controls, removes, or destroys” proliferating cancer tissue. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as “Other Treatment” (Code 1) for certain **hematopoietic disease ONLY**. Consult the most recent version of the *Hematopoietic Manual and Database* for instructions to code other treatments for a specific disease.
- Code 1 for embolization using alcohol as an embolizing agent and for embolization to a site other than the liver where the embolizing agent is unknown. Do not code presurgical embolization that is given only to shrink the tumor.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)
- Code 8 if it is known that a physician recommended treatment as Other Treatment, and no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a specialist for Other Treatment the registry can follow. If follow up with the specialist or facility determines the patient was never there, code 0.

Date Other Treatment Started

Records the start date for other treatments which cannot be coded as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Instructions for Coding:

- Record the date on which the care coded as *Other Treatment* was initiated.
- If other treatment is the first or only treatment administered to the patient, then the *Date Other Treatment Started* must be the same as the *Date of First Course of Treatment*.
- Record the date as completely as possible. Leave any unknown positions of the date blank.
- **RX Date – Other Flag** explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started*.

Palliative Procedure

Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy and/or other pain management therapy. This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Instructions for Coding:

- Record the type of palliative care provided
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable must be coded palliative care and as first course therapy if that procedure removes or modifies either primary or metastatic malignant tissue
- Palliative care is not used to diagnose or stage the primary tumor
- Do not code routine pain management following surgery or other treatment, do not code first course pain management for persistent pain

Recurrence

Recurrence indicates the return of the cancer after a period of remission or after the patient has experienced a period of documented disease-free intermission. Use this field for **first recurrence only**.

Instructions for Coding:

- Codes 00-70 are hierarchical. Record the highest-numbered applicable response.
- Use codes "06, 16, 17, 26, 27, 36, or 46" for tumors that are originally diagnosed as in situ. Do not use these codes for any other tumors.
- Codes 00, 88, or 99 may apply to any tumor.
- Codes 51-59 apply only if all first occurrences were in a single category. There may be multiple metastases within the distant location.
- Code **00** for lymphoma or leukemias that are in remission. If the patient relapses, then code recurrence status as **59**.
- If the patient has more than one primary and the physician does not state which cancer has recurred, code the recurrent disease to each tumor and at later date if the recurrent primary is identified, revise the codes appropriately.

Date of First Recurrence

Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period. Recurrence date flag explains why there is no appropriate value in the corresponding date field, *Date of First Recurrence*.

Refer to *STORE Section Two, Coding Instructions* for complete instructions

Chapter 9 – Outcome Information

Date of Last Contact or Death

This field records the date of last contact with the patient or the date of death. This information is used for patient follow-up and outcome studies.

Instructions for Coding:

- Record the date which the patient was known to be alive or date of death
- If a patient has multiple primaries, all records must have the same date of last contact
- As of January 1, 2006, CoC does not require class 00 cases to be followed
- Record the date as completely as possible. Leave any unknown portions of the date blank.

Date of Last Contact Flag

This data item explains why there no appropriate value in the corresponding date field, *Date of Last Contact or Death*.

Instructions for Coding:

- Leave this item blank if *Date of Last Contact or Death* has a full or partial date recorded
- Code 12 if the *Date of Last Contact or Death* cannot be determined

Vital Status

Record the patient's vital status at the date of the last contact. If a patient has multiple primaries, all records must have the same vital status code.

- 0 - Dead
- 1 - Alive

Cancer Status

Records the presence or absence of clinical evidence of the reported primary at the date the patient was last known to be alive, or at the date of death.

Instructions for Coding:

- Cancer status is based on information from the patient's physician or other official source such as death certificate
- The patient's cancer status must only be changed if new information is received from the patient's physician or other official source. If information is obtained from the patient's family member, or other non-physician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Underlying Cause of Death

This information may be found on the death certificate or in the medical record. If the Date of Last Contact or Death is on or after 1/1/2000, the cause of death must be coded in the abstract using ICD-10-CM. If the death certificate/death information is not available or the field is not applicable use the following codes:

- 0000 – Patient alive at last contact
- 7777 – State death certificate or listing not available

- 7797 – State death certificate or listing available, underlying cause of death not coded

Note: Death certificate from the Arkansas Bureau of Vital Statistics are coded using ICD-10-CM.

ICD Revision Number

Enter the ICD-Edition that applies for the date of death

- 0 – Patient alive at last contact
- 1 – ICD-10 (date of death on or after 1/1/2000)
- 9 – ICD-9 (date of death before 1/1/2000)

Chapter 10 – Text Fields

ACCR frequently receives abstracts from multiple facilities that must be consolidated into one case. Thus, abstracts must contain coordinating text in order for ACCR to assure that what is entered into the ACCR database is the most accurate information for each case reported. The operative concept here is “corroborating”. That is, text must provide the rationale for selecting the codes assigned to primary site, histology, extent of disease, and treatment fields. Brief, meaningful comments are all it takes to tell us what we need to know.

Text is also evaluated in some data quality audits to ensure coding accuracy and completeness. Missing or inadequate text to support the coded fields results in unnecessary errors affecting final statistical results of an audit.

One way to improve your text is to fill in the text fields first as you abstract, then code fields from that information. While it may feel awkward at first, it will show you how important accurate text is to ACCR. These required text fields are considered in our QA and auditing process, so good text entries may save you questions later.

Tips:

- Enter relevant information only
- Include only information that the registry is authorized to collect (think HIPAA)
- If information is unavailable, state so in the text

Please refer to Minimum Text Requirements, General and by Site on ACCR utilities website (<https://adhcancer.arkansas.gov/>) for specifics.

Appendix A – Helpful Links

ACCR Home Page

<http://www.healthy.arkansas.gov/programs-services/topics/arkansas-cancer-registry>

ACCR Utilities Page – Instructions, Reportable List, and EDITS Metafiles

<https://adhcancer.arkansas.gov/>

Web Plus Login

<https://adhcancer.arkansas.gov/WebPlus/logonen.aspx>

ADH Meaningful Use

<http://www.healthy.arkansas.gov/programs-services/topics/meaningful-use>

Arkansas Cancer Rates

<https://www.cancer-rates.info/ar/>

SEER Home Page

<https://seer.cancer.gov/>

CDC NPCR Home Page

<https://www.cdc.gov/cancer/npcr/index.htm>

NAACCR Data Dictionary

<http://datadictionary.naaccr.org/>

CoC Coding Manual

<https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals>

SEER Coding and Staging Manuals

<https://seer.cancer.gov/tools/codingmanuals/>

SEER*RSA (Registrar Staging Assistant

https://staging.seer.cancer.gov/eod_public

NAACCR Site Specific Data Items (SSDI) Coding Instructions

<https://apps.naaccr.org/ssdi/list/>

Collaborative Staging Coding Manuals

<https://cancerstaging.org/cstage/schema/Pages/version0205.aspx>

Appendix B – State Law

See ACCR's website for the *Arkansas Board of Health Statewide Cancer Registry Act and Rules Pertaining to the Arkansas Cancer Registry*:

<https://www.healthy.arkansas.gov/programs-services/topics/arkansas-cancer-registry>

Appendix C – Cancer Registries and HIPAA

§ 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written consent or authorization of the individual as described in §§ 164.506 and 164.508, respectively, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) Standard: uses and disclosures required by law.

(1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) Standard: uses and disclosures for public health activities.

(1) Permitted disclosures. A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority

Appendix D – Medical Abbreviation List

Abbreviations which are acceptable to use when abstracting cases are listed below. For abbreviated names of Antineoplastic Drugs see *SEER Program Self-Instructional Manual for Tumor Registrars, Book 8, Third Edition* or *SEER RX website*.

Abdomen	ABD	Cervical Intraepithelial Neoplasia	CIN
Abdominal Perineal	AP	Cervix	CX
Acid Phosphatase	ACID PHOS	Cesium	CS
Acquired Immunodeficiency Syndrome	AIDS	Chemotherapy	CHEMO
Acute Granulocytic Leukemia	AGL	Chest X-ray	CXR
Acute Lymphocytic Leukemia	ALL	Chief Complaint	CC
Acute Myelogenous Leukemia	AML	Chronic Granulocytic Leukemia	CGL
Adenocarcinoma	ADENOCA	Chronic Lymphocytic Leukemia	CLL
Adjacent	ADJ	Chronic Myeloid Leukemia	CML
Admission, Admit	ADM	Clear	CLR
Alcohol	ETOH	Common Bile Duct	CBD
Alkaline Phosphatase	ALK PHOS	Complete Blood Count	CBC
Alpha-fetoprotein	AFP	Computerized Axila Tomography Scan	CT, CAT
Also known as	AKA	Consistent With	C/W
Ambulatory	AMB	Continue	CONT
Anaplastic	ANAP	Cystoscopy	CYSTO
Anterior	ANT	Cytology	CYTO
Anteroposterior	AP	Date of Birth	DOB
Approximately	APPROX	Death Clearance Only	DCO
Arteriovenous	AV	Decreased	DECR (<)
Aspiration	ASP	Dermatology	DERM
Auscultation & Percussion	A & P	Diagnosis	DX
Autopsy	AUT	Diameter	DIA
Axillary	AX	Differentiated	DIFF
Bacillus Calmette-Guerin	BCG	Dilation & Curettage	D & C
Barium	BA	Discharge	DIS, DISC
Barium Enema	BE	Discontinued	DC
Benign Prostatic Hypertrophy/hyperplasia	BPH	Disease	DZ, DIS
Bilateral	BIL	Doctor	DR, MD

Bilateral Salpingo-oophorectomy	BSO	Ears, Nose, & Throat	ENT
Biological Response Modifier	BRM	Emergency Room	ER
Biopsy	BX	Enlarged	ENL
Blood Urea Nitrogen	BUN	Esophagogastroduodenoscopy	EGD
Bone Marrow	BM	Estrogen Receptor	ER
Bone Scan	BSC	Evaluation	EVAL
Calcium	CA	Examination	EXAM
Carcinoembryonic Antigen	CEA	Examination under anesthesia	EUA
Carcinoma	CA	Excision	EXC
Carcinoma In Situ	CIS	Exploratory Laparotomy	EXP LAP
CAT Scan	CT	Extend, Extension	EXT
Centimeter	CM	External	EXT
Central Nervous System	CNS	Extremity	EXT
Cerebrospinal Fluid	CSF	Eyes, ears, nose, & throat	EENT
Family History	FH	Midclavicular line	MCL
Floor of mouth	FOM	Middle lobe	ML
Follow-up	FU	Millimeter	MM
Frozen Section	FS	Minimum	MIN
Gastroenterostomy	GE	Moderate	MOD
Gastrointestinal	GI	Moderately Differentiated	MD, MOD DIFF
Grade	GR	Modified Radical Mastectomy	MRM
Gynecology	GYN	Nausea & Vomiting	N & V
Head, Eyes, Ears, Nose, & Throat	HEENT	Negative	NEG (or -)
Hematocrit	HCT	Neurology	NEURO
Hemoglobin	HGB	No evidence of disease	NED
History	HX	Normal	NL
History & Physical	H & P	No significant findings	NSF
History of	HO	Not applicable	NA
History of Present Illness	HPI	Not otherwise specified	NOS
Hormone	HORM	Not recorded	NR
Hospital	HOSP	Obstructed (ing, ion)	OBST
Human Chorionic Gonadotropin	HCG	Operating Room	OR
Human Immunodeficiency Virus	HIV	Operative report	OP report
Hysterectomy	HYST	Outpatient	OP
Immunoglobulin	IG	Packs per day	PPD
Includes, including	INCL	Palpated	PALP
Increase	INCR (or>)	Papanicolaou Smear	PAP
Infiltrating	INFILT	Papillary	PAP
Inpatient	IP	Past Medical History	PMH
Intravenous	IV	Pathology	PATH

Intravenous Pyelogram	IVP	Patient	PT
Kidneys, Ureter, Bladder	KUB	Percutaneous	PERC
Laparotomy	LAP	Physical Examination	PE
Lateral	LAT	Platelets	PLT
Left	L, LT	Poorly differentiated	PD, POOR DIFF
Left Costal Margin	LCM	Positive	POS (or +)
Left lower extremity	LLE	Positron Emission Tomography	PET
Left lower lobe	LLL	Possible	POSS
Left lower quadrant	LLQ	Posterior	POST
Left upper extremity	LUE	Posteroanterior	PA
Left upper lobe	LUL	Postoperative	PO, POSTOP
Left upper quadrant	LUQ	Preoperative	PREOP
Liver, kidney, spleen, (bladder)	LKS(B)	Present Illness	PI
Lower extremity	LE	Prior to admission	PTA
Lower inner quadrant	LIQ	Probable	PROB
Lower outer quadrant	LOQ	Progesterone receptor	PR
Lumbar puncture	LP	Pulmonary	PULM
Lumbosacral	LS	Radiation	RAD
Lymph Node(s)	LN, LNs, LNS	Radiation absorbed dose	RAD
Macroscopic	MACRO	Radiation therapy	RT
Magnetic Resonance Imaging	MRI	Radical	RAD
Malignant	MALIG, MAL	Radium	RA
Mastectomy	MAST	Red blood cells	RBC
Maxillary	MAX	Resection	RESEC
Medicine	MED	Respiratory	RESPIR
Metastatic, Metastases	MET, METS	Review of systems	ROS
Microscopic	MICRO	Right	R, RT
Right costal margin	RCM	Transurethral Resection	TUR
Right lower extremity	RLE	Transurethral Resection Bladder	TURB
Right lower lobe	RLL	Transurethral Resection Prostate	TURP
Right lower quadrant	RLQ	Treatment	RX, TX
Right middle lobe	RML	Undifferentiated	UNDIFF
Right upper extremity	RUE	Upper extremity	UE
Right upper lobe	RUL	Upper gastrointestinal	UGI
Right upper quadrant	RUQ	Upper inner quadrant	UIQ
Rule out	RO, R/O	Upper outer quadrant	UOQ
Salpingo-oophorectomy	SO	Vagina, Vaginal	VAG
Shortness of breath	SOB	Vaginal Hysterectomy	VAG HYST
Specimen	SPEC	Vaginal intraepithelial neoplasia	VAIN
Small	SM, SML	Vascular	VASC
Small bowel	SB, SML BWL	Vulvar intraepithelial neoplasia	VIN
Squamous	SQ, SQUAM	Well differentiated	WD, WELL DIFF
Squamous Cell Carcinoma	SCC	White blood cells	WBC
Status post	S/P	With	W/ or C
Surgery, Surgical	SURG	Within normal limits	WNL

Symptoms	SX	Without	W/O
Total Abdominal	TAH-BSO	Work-up	W/U
Hysterectomy + Bilateral			
Salpingo-oophorectomy			
Total Vaginal	TVH	X-ray	XR
Hysterectomy			
Transitional Cell	TCC	Year	YR
Carcinoma			

Appendix E – Surgery and Cancer Treatment

Surgery is the oldest form of cancer treatment. It also has a key role in diagnosing cancer and finding out how far it has spread (staging). Advances in surgical techniques have allowed surgeons to successfully operate on a growing number of patients. Today, less invasive operations often can be done to remove tumors while saving as much normal tissue and function as possible.

Surgery offers the greatest chance for cure for many types of cancer, especially those that have not spread to other parts of the body. Most people with cancer will have some type of surgery.

Why is surgery used for cancer?

Surgery can be done for many reasons. Some types of surgery are very minor and may be called procedures, while others are much bigger operations. The more common types of cancer surgeries are reviewed here.

Preventive (prophylactic) surgery

Preventive surgery is done to remove body tissue that is likely to become cancerous (malignant), even though there are no signs of cancer at the time of the surgery. For example, pre-cancerous polyps may be removed from the colon.

Sometimes preventive surgery is used to remove an entire organ when a person has an inherited condition that puts them at a much higher risk for having cancer someday. For example, some women with a strong family history of breast cancer are found to have a change (mutation) in their DNA in a breast cancer gene (BRCA1 or BRCA2). Because their risk of getting breast cancer is high, these women may want to consider prophylactic mastectomy (the breasts are removed before cancer is found).

Diagnostic surgery

This type of surgery is used to get a tissue sample to tell whether or not cancer is present or to tell what type of cancer it is. The diagnosis of cancer is often made by looking at the cells under a microscope. Many methods are used to get a sample of cells from a suspicious-looking area. These are described in the section, "Surgery to diagnose and stage cancer."

Staging surgery

Staging surgery is done to find out how much cancer there is and how far it has spread. While the physical exam and the results of lab and imaging tests can help figure out the clinical stage of the cancer, the surgical stage (also called the pathologic stage) is usually a more exact measure of how far the cancer has spread.

Examples of surgical procedures commonly used to stage cancers, such as laparotomy and laparoscopy, are described in the section, "Surgery to diagnose and stage cancer."

Curative surgery

Curative surgery is done when a tumor appears to be confined to one area, and it is likely that all of the tumor can be removed. Curative surgery can be the main treatment for the cancer. It may be used alone or along with chemotherapy or radiation therapy, which can be given before or after the operation.

Sometimes radiation therapy is actually used during an operation. This is called intraoperative radiation therapy.

Debulking (cytoreductive) surgery

Debulking surgery is done to remove some, but not all, of the tumor. It is done when removing the entire tumor would cause too much damage to an organ or near-by tissues. In these cases, the doctor may remove as much of the tumor as possible and then try to treat what's left with radiation therapy or chemotherapy. Debulking surgery is commonly used for advanced cancer of the ovary.

Palliative surgery

This type of surgery is used to treat complications of advanced cancer. It is not intended to cure the cancer. Palliative surgery can also be used to correct a problem that is causing discomfort or disability. For example, some cancers in the abdomen may grow large enough to block off (obstruct) the intestine. If this happens, surgery can be used to remove the blockage. Palliative surgery may also be used to treat pain when the pain is hard to control by other means.

Supportive surgery

Supportive surgery is used to help with other types of treatment. For example, a vascular access device such as a port-a-cath can be surgically placed into a large vein. The port can then be used to give treatments or draw blood for testing, instead of having needles put in the arms.

Restorative (reconstructive) surgery

This type of surgery is used to change the way a person looks after major cancer surgery or to restore the function of an organ or body part after surgery. Examples include breast reconstruction after mastectomy or the use of tissue flaps, bone grafts, or prosthetic (metal or plastic) materials after surgery for oral cavity cancers. For more information on these types of reconstructive surgery, please see the American Cancer Society documents [Breast Reconstruction after Mastectomy](#) and [Oral Cavity and Oropharyngeal Cancer](#).

Surgery to diagnose and stage cancer

A biopsy is a procedure done to remove a tissue sample so that it can be looked at under a microscope. Some biopsies may need to be done in surgery, but many types of biopsies involve removing tumor samples through a thin needle or an endoscope (a flexible lighted tube). Biopsies are often done by surgeons, but they can be done by other doctors, too. Some of the more common ways to do a biopsy are reviewed here.

Fine needle aspiration biopsy

Fine needle aspiration (FNA) uses a very thin needle attached to a syringe to pull out a small amount of tissue from a tumor. If the tumor can't be felt near the surface of the body, the needle can be guided into the tumor by looking at it with an imaging method such as an ultrasound (US) or CT (computed tomography) scan.

The main advantage of FNA is that no surgical incision (cutting through the skin) is needed. A drawback is that in some cases the needle can't take out enough tissue for a definite diagnosis. A more invasive type of biopsy may then be needed.

Core needle biopsy

This type of biopsy uses a slightly larger needle to take out some of the tissue. A core biopsy can be aspirated (removed) with a needle if the tumor can be felt at the surface. Core biopsies can also be guided by imaging methods if the tumor is too deep to be felt.

The advantage of core biopsy is that it usually collects enough tissue to find out whether or not the tumor is cancer.

Excisional or incisional biopsy

For these biopsies a surgeon cuts through the skin to remove the entire tumor (excisional biopsy) or a small part of the tumor (incisional biopsy). They can often be done with local or regional anesthesia. This means numbing medicine is used just in the area where the biopsy will be done. If the tumor is inside the chest or abdomen, general anesthesia (drugs that put you into a deep sleep) may be needed.

Endoscopy

This procedure uses a thin, flexible tube with a viewing lens or a video camera and a fiber optic light on the end. If a video camera is used, it is connected to a television screen. This allows the doctor to clearly see any tumors in the area. Endoscopes can be passed through natural body openings to look at areas of concern in places such as the following:

- throat (pharyngoscopy)
- voice box (laryngoscopy)
- esophagus (esophagoscopy)
- stomach (gastrosocopy)
- small intestine (duodenoscopy)
- colon (colonoscopy or sigmoidoscopy)
- bladder (cystoscopy)
- respiratory tract -- windpipe, bronchi, and lungs (bronchoscopy)

Some of the advantages of endoscopy are:

- The doctor can look right at the tumor and get a good idea of where it is and how big it is.
- A biopsy can be taken through the scope to find out if the tumor is cancer.
- An open surgical incision or general anesthesia is usually not needed.

Local numbing medicines are needed before some types of endoscopy. Medicines may also be given to make you sleepy.

Ultrasonography

Ultrasound devices can be attached to the end of some endoscopes. This allows doctors to look at the layers of the esophagus (swallowing tube), bronchus (main breathing tube), and parts of the large intestine (bowel). Nearby lymph nodes can be seen, too. Using the ultrasound pictures to guide it, a needle can be placed through the endoscope and cells can be collected from lymph nodes that do not look normal.

Laparoscopy, thoracoscopy, or mediastinoscopy

Laparoscopy is much like endoscopy, but a small incision is made in the skin of the abdomen (belly). A thin tube called a laparoscope is then put through the incision and into the abdomen to look for possible areas of cancer that can be biopsied. When this type of procedure is done to look inside the chest it is called a thoracoscopy or mediastinoscopy.

Open surgical exploration (laparotomy, thoracotomy, or mediastinotomy)

When less invasive tests do not give enough information about a suspicious area in the abdomen, a laparotomy may be needed. In this procedure, a surgeon makes an incision, usually from the bottom of the

sternum (breastbone) down to the lower part of the abdomen (belly), which allows him to look directly at the area in question. The location and size of the tumor and the surrounding areas can be seen and biopsies can be taken, if needed. Because this is a major surgical procedure, general anesthesia (medicines that put you in a deep sleep) is needed. An operation much like this can be done to open and look inside the chest. It is called a thoracotomy.

If lymph nodes near the trachea are swollen, a mediastinotomy is done. General anesthesia (medicines that put you in a deep sleep) is used for this procedure. A special scope (mediastinoscope) is put in the body through a small incision above the top of the sternum (breastbone) and biopsies are collected from the areas of concern.

Special Surgery Techniques

When most people think of surgery, they picture a doctor using a scalpel and other surgical instruments to remove, repair, or replace parts of the body affected by disease. But newer techniques, using different types of instruments, have expanded the concept of what surgery is. Some of these newer techniques are described below.

Laser surgery

A laser is a highly focused and powerful beam of light energy which can be used for very precise surgical work, such as repairing a damaged retina in the eye. It can also be used to cut through tissue (instead of using a scalpel) or to vaporize (burn and destroy) cancers of the cervix, larynx (voice box), liver, rectum, or skin.

Some surgeries can be made less invasive by using laser light. For example, with fiber optics the light can be directed inside the body without having to make a large incision.

Lasers are also used in a type of surgery called photoablation or photocoagulation. This means lasers are used to destroy tissue or to seal tissues or vessels. This type of surgery is often used to relieve symptoms, such as when large tumors block the windpipe or esophagus, causing problems with breathing or eating.

Cryosurgery

Cryosurgery involves the use of a liquid nitrogen spray or a very cold probe to freeze and kill abnormal cells. This technique is sometimes used to treat pre-cancerous conditions, such as those affecting the cervix. Cryosurgery is also being studied as a treatment for some cancers, such as those of the prostate.

Electrosurgery

High-frequency electrical current can be used to destroy cells. It is used for some cancers of the skin and mouth.

Mohs surgery

Mohs micrographic surgery, also called microscopically controlled surgery, is a technique to remove certain skin cancers by shaving off one thin layer at a time. After each layer is removed, a specially trained dermatologist (skin doctor) or a pathologist (doctor who specializes in diagnosing and classifying diseases by lab tests) looks at the tissue layer under a microscope. When all the cells look normal under the microscope, the surgeon stops removing layers of tissue.

This technique is used when the extent of the cancer is not known or when as much healthy tissue as possible needs to be preserved (as in cancers around the eye). It is done under local anesthesia by a specially trained surgeon.

Chemosurgery is an older name for this surgery and refers to certain chemicals put on the tissue before it is removed. Mohs surgery does not involve use of cancer chemotherapy drugs.

Laparoscopic surgery

A laparoscope is a long, narrow, flexible tube placed through a small incision (cut) to look inside the body. It is sometimes used to take biopsy samples. In recent years, doctors have found that by creating some small holes and using special instruments, the laparoscope can be used to perform surgery without making a large incision. This can help reduce blood loss during surgery and pain afterwards. It can also shorten hospital stays. Laparoscopic surgery is commonly used today to remove gallbladders and to repair hernias.

The role of laparoscopic surgery in cancer treatment is not yet clear. Doctors are now studying whether it is safe and effective to use laparoscopic surgeries for many cancers of the bladder, colon, prostate, and kidney, among others. It may prove to be as safe and effective as standard surgery while being less invasive. Some studies have hinted at this being the case. But larger, long-term studies still need to be completed.

Thorascopic surgery

A thoracoscope is a narrow, rigid tube with a camera connected at one end that can be placed through a small incision (cut) into the chest after the lung is collapsed. This allows the doctor to see inside the entire chest. Any areas of concern on the lining of the chest wall can be biopsied, fluid can be drained, and small tumors on the surface of the lung can be removed with small stapling devices. This less-invasive approach has also been used to remove parts (lobes) of the lung that contain cancer. Studies have shown that for early stage lung cancer, results are much like removing part of the lung by doing an open thoracotomy (incision in the side of the chest).

Other forms of surgery

Newer ways to remove or destroy cancer tumors are always being explored. Some methods are beginning to blur the lines between what we commonly think of as "surgery" and other forms of treatment. Researchers are testing many new techniques, using things such as high intensity focused ultrasound (HIFU); microwaves or radio waves (radiofrequency ablation, or RFA); or even magnets in an attempt to get rid of unwanted tissue. While promising, these techniques are still largely experimental.

As doctors learn how to better control the energy waves used in radiation therapy, some newer radiation techniques that are almost as effective as surgery have been found. By using radiation sources from different angles, stereotactic radiation therapy delivers a large precise radiation dose to a small tumor area. The doses are so exact that the term stereotactic surgery is sometimes used, even though no incision (cut) is actually made. In fact, the machines used to deliver this treatment have names like Gamma Knife and Cyber Knife, although no actual knife is involved. The most common site being treated with this technique is the brain, but it is also being used in head, neck, lung, and spine tumors. Researchers are looking for ways to use it to treat other types of cancer, too.

Appendix F – Glossary of Treatment Terms

GLOSSARY OF TREATMENT TERMS (referenced from the training manual prepared by the American College of Surgeons Commission on Cancer)

Abdominal-perineal resection: Surgical procedure used in the treatment of colorectal Cancer that requires a combined approach through the abdomen and the perineum. Complications include ureteral injury, urinary dysfunction, urinary tract infections, sexual dysfunction, perineal and abdominal wound infections, and stomal complications.

Adjuvant therapy: A therapy that aids another, such as chemotherapy, after surgery.

Allogeneic bone marrow transplantation: Transplanting bone marrow from one person to another person who is of the same tissue type.

Amputation: The removal of a limb or another appendage or outgrowth of the body.

Antioncogenes: Genes having the ability to regulate growth and inhibit carcinogenesis.

Antrectomy: Excision of the antrum.

Autologous bone marrow transplantation: Transplanting the patient's own bone marrow after ablative treatment.

BCG: Bacille Calmette Guerin vaccine, a tuberculosis vaccine, containing living, avirulent, bone-strain tubercle bacilli. It is administered by a special technique using a multiple puncture disk and is used immunotherapy for the treatment of cancer, particularly malignant melanoma and bladder cancer.

Bilobectomy: Removal of two lobes.

Billroth I: Pylorectomy with end-to-end anastomosis of the upper portion of the stomach to the duodenum.

Billroth II: Partial gastric resection with closure of duodenal stump and gastrojejunostomy.

Biopsy: Removal and examination, usually microscopic, of tissue from the living body. Biopsies are done to determine whether a tumor is malignant benign.

Excisional: The entire lesion is removed by surgical cutting

Incisional: Biopsy of a selected portion of a lesion

Needle aspiration: Biopsy in which tissue is obtained by application by suction through a needle attached to a syringe

Punch: A type of incisional biopsy

Shave: A type of incisional biopsy since the tumor is rarely totally removed

Brachytherapy: Radiation from a source placed within the body or a body cavity.

Cecetomy: Excision of the cecum.

Cecocolostomy: Surgical anastomosis of the ileum to the cecum.

Cervicectomy: Excision of the cervix utero.

Cholecystectomy: Excision of the gallbladder.

Cholecystojejunostomy: Surgical anastomosis of the gallbladder and jejunum.

Colectomy: Excision of the colon or a portion of it.

Colony-stimulating factor (CSF): Soluble protein factors that stimulate division and maturation of bone marrow stem cells. All CSFs are named a function of the cell most responsive to the factor (e.g., granulocyte colony-stimulating factor or GCSF).

Coloproctectomy: Surgical removal of the colon and rectum.

Colposcopy: The process of examining the vagina and cervix by means of a speculum and a magnifying lens; procedure used for the early detection of malignant changes on the cervix/vagina cuff.

Conization: The removal of a “cone” of tissue, as a partial excision of the cervix. This can be done with a scalpel or electrocautery; the scalpel technique preserves the histologic elements of the tissue better.

Continent urinary reservoir (Continent ileal reservoir): Also called the “kock pouch”; a surgical procedure which provides an intra-abdominal pouch that stores urine and has two nipples valves that maintain continence and prevent ureteral reflux.

Craniotomy: Any surgical operation on the cranium.

Cryoprostectomy: Destruction of the prostate by the application of extreme cold.

Cryosurgery: The destruction of tissue by application of extreme cold.

Cystectomy: Excision of the urinary bladder or a part of it.

Debulking: Surgery to reduce tumor to aggregates of 2 cm. Or less; improves the response to postoperative chemotherapy.

Duodenostomy: Surgical formation of a permanent opening into the duodenum.

Endoscopic retrograde cholangiopancreatogram (ERCP): A procedure consisting of a combination of retrograde cholangiography and transhepatic cholangiography used to visualize all portions of the biliary tree.

Enterectomy: An excision of a portion of the intestine.

Esophagectomy: An excision of a portion of the esophagus.

Esophagocoloplasty: An excision of a portion of the esophagus and its replacement by a segment of the colon.

Esophageoenterostomy: An excision of the esophagus and the stomach.

Esophagoscopy: Direct visual examination of the esophagus with an esophagoscope.

Fulguration: Destruction of living tissue by electric sparks generated by a high frequency current.

Gastrectomy: Excision of all (total) or a portion (partial or subtotal) of the stomach.

Glossectomy: Excision of all or a portion of the tongue.

Gray: The S1 (Système International d’Unités) unit of absorbed radiation dose, defined as the transfer of 1 joule of energy per Kg of absorbing material. 1 Gray = 100 rads.

Hartmann’s operation: Resection of a portion of the colon, with the proximal end of the colon brought out as a colostomy and the distal stump or rectum being closed.

Hemicolectomy: Excision of approximately half of the colon.

Hepatectomy: Excision of all or a portion of the liver.

Hysterectomy: Surgical removal of the uterus.

Abdominal: performed through the abdominal wall

Modified radical (type2): removal of the uterus a portion of the parametrium

Radical or Wertheim procedure (type3): removal of the uterus and excision of the pelvic lymph nodes with wide lateral excision of the parametrical and paravaginal supporting structure

Simple (type 1): removal of the uterus

Subtotal: the cervix is left in place

Total (pan): the uterus and cervix are completely excised

Vaginal: performed through the vagina

Ileal conduit: A surgical procedure that uses a segment of the ileum for the diversion of urinary flow from the ureters.

Ileocelectomy: Excision of the ileum and part of the colon.

Ileocolostomy: Surgical anastomosis of the ileum to the colon.

Immunotherapy: Passive immunization of an individual by administration of performed antibodies actively produced in another individual (serum or gamma globulins). The term has also come to include the use of immunopotentiators, replacement of immunocompetent tissue (bone marrow), and infusion of specially-treated white blood cells.

Intensification therapy (also called reintensification therapy): This therapy has been proposed to prevent the return of the leukemic cell population. After one year of sustained, complete remission, the person undergoes the same intensive induction therapy as in the initial treatment period. The objective is bone marrow depression. After recovery of the bone marrow depression, the person continues on maintenance therapy for another year.

Interferon: Natural glycoprotein released by cells invaded by viruses or certain infectious agents; acts as a stimulant to noninfected cells, causing them to synthesize another protein with antiviral capabilities. Interferons are divided into these subsets, with each originating from a different cell and having distinctive chemical and biologic properties:

Alpha: produced by leukocytes in response to a viral infection

Beta: produced by fibroblasts in response to a viral infection

Gamma: produced by lymphoid cells in culture that is stimulated by a mitogen

Interleukin-2: Glycoprotein produced by helper T-cells that is an essential factor in the growth of T-cells and seems to induce the production of interferon. It is used as an anti-cancer drug in the treatment of a wide variety of solid tumors.

Intrathecal chemotherapy: Cytotoxic drugs injected into the cerebrospinal fluid (CSF), thus bypassing the blood-brain barrier.

Intravesical chemotherapy: Chemotherapy administered via a Foley catheter for the treatment of bladder cancer. The Foley is then usually clamped for a period of time and then emptied. This procedure delivers a

high local concentration to the tumor area. Patients receiving this therapy require life-long cystoscopic surveillance for recurrent disease.

Jejunostomy: Surgical creation of a permanent opening between the jejunum and the surface of the abdominal wall.

Laminectomy: Excision of the lamina.

Laryngectomy: Partial or total removal of the larynx.

Laryngopharyngectomy: Excision of the larynx and pharynx.

LEEP: Loop Electrosurgical Excision Procedure uses an electrical current passed through a thin wire to loop to act as a knife to excise tissue.

Limp perfusion: Used in the treatment of malignant melanoma, where certain chemotherapeutic drugs (usually L-phenylalanine and DTIC) are instilled into the affected extremity by arterial perfusion. A pump system counteracts the normal arterial pressure, permitting a steady state of infusion, allowing the drugs to have the greatest effect at the disease site, usually performed after surgical removal of the bulk of the tumor mass.

Lingulectomy: Excision of the lingual of the left lung.

Lumpectomy: (tylectomy) Excision of only the local lesion in carcinoma of the breast.

Lymphadenectomy: Excision of one or more lymph nodes.

Lymphangiography: The film produced by lymphangiography, which is an x-ray of the lymphatic channels after introduction of a contrast medium.

Mandibulectomy: Excision of the mandible.

Mastectomy: Surgical removal of breast tissue.

Extended radical: Supraradical mastectomy; surgical removal of the internal mammary chain of lymph nodes, the entire involved breast, the underlying chest muscle, and the lymph nodes in the axilla.

Halstead radical: surgical en bloc removal of the entire involved breast, the underlying chest muscles, and the lymph nodes in the axilla.

Modified radical: surgical removal of the entire involved breast and many lymph nodes in the axilla. The underlying chest muscles are removed in part or are left in after removal of axillary lymph nodes.

Partial: removal of the tumor along with varying amounts of surrounding normal tissue (also called segmental, tylectomy, or quadrantectomy).

Simple (total): surgical removal of the entire involved breast with or without the underlying chest muscles, and axillary lymph node dissection is not done.

Subcutaneous: excision of the breast tissue with preservation of overlying skin, nipple, and areola.

Neck dissection: Excision of lymph nodes in neck area.

Modified radical neck: the same lymph nodes are removed as in a radical neck dissection; however one or more non-lymphatic structures are preserved

Radical neck dissection: includes the removal of all ipsilateral cervical lymph node groups (i.e., lymph nodes from levels I through V or submental, submandibular, cranial jugular, medical jugular, caudal jugular, dorsal cervical nodes along the accessory nerve and supraclavicular) and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

Selective neck dissection: preserves one or more lymph node groups routinely removed in a radical neck dissection

Nephrectomy: Surgical removal of a kidney and usually Gerota's fascia, perinephric fat; renal vein, and appropriate lymph nodes.

Nephroureterectomy: Removal of the kidney and ureter.

Omentectomy: Excision of all or part of the omentum.

Ommaya Reservoir: This device is a subcutaneous cerebrospinal fluid (CSF) reservoir that is implanted surgically under the scalp and provides access to the CSF through a burr hole in the scalp. Drugs are injected into the reservoir with a syringe, and the domed reservoir is then depressed manually to mix the drug within the CSF. This device eliminates the need for multiple lumbar punctures in the repeated administration of intrathecal chemotherapy.

Oophorectomy: Excision of one or both ovaries; also called ovariectomy.

Orchiectomy: Surgical removal of one or both testis.

Pancreatectomy: Excision of the pancreas.

Pancreaticoduodenostomy: Anastomosis of the pancreatic duct to a different site on the duodenum.

Pancreaticogastrostomy: Anastomosis of the pancreatic duct to the stomach.

Pancreaticojejunostomy: Anastomosis of the pancreatic duct to the jejunum.

Pancreaticoduodenectomy: Excision of the head of the pancreas and the adjacent portion of the duodenum.

Parotidectomy: Excision of a parotid gland.

Pelvic exenteration: Surgical removal of all reproductive organs and adjacent tissue.

Anterior: includes the bladder, distal ureters and genital organs with their ligamentous attachments and pelvic lymph nodes

Extended: includes pelvic blood vessels or bony pelvis

Posterior: includes the rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes

Total: includes removal of all pelvic contents and pelvic lymph nodes. A radical hysterectomy, pelvic lymph node dissection, removal of the bladder, distal ureters and genital organs with their ligamentous attachments.

Pharyngectomy: Excision of part of the pharynx.

Pharyngolaryngectomy: Excision of the pharynx and larynx.

Photodynamic therapy: A photosensitizing drug is exposed to specific wavelengths of light in the presence of oxygen.

Pneumonectomy: Excision of lung tissue.

Lobectomy: excision of a single lobe

Partial: excision of less than the entire lung

Total: excision of the entire lung

Proctectomy: Excision of the rectum.

Proctectomy: Excision of the rectum and lower colon.

Prostatectomy: Excision of the prostate.

Quadrantectomy: Removal of one-fourth of the tissue.

Rectosigmoidectomy: Excision of the rectosigmoid colon; also called a proctosigmoidectomy.

Salpingo-oophorectomy: Excision of the fallopian tube and ovary.

Sigmoidectomy: Excision of the sigmoid colon.

Sigmoidoscopy: Direct examination of the interior of the sigmoid colon.

Splenectomy: Excision of the spleen.

Stereotactic surgery: A surgical technique used in neurology in which precise localization of the target tissue is possible through use of three-dimensional coordinates, also known as stereotaxis surgery.

Thermal ablation: Destruction of tissue with heat.

Thyroidectomy: Excision of the thyroid gland.

Subtotal: more than two-thirds of the gland is removed

Total: the entire gland is removed

Total abdominal hysterectomy with bilateral salpingectomy and oophorectomy (TAHBSO): Total removal of the uterus and the cervix performed through the abdominal wall rather than the vagina route, in addition, the fallopian tubes and the ovaries are removed bilaterally.

Trachelectomy: Excision of the uterine cervix.

Transurethral resection of prostate (TURP): Removal of a portion of the prostate gland by means of an instrument passed through the urethra. This procedure removes only enlarged prostatic tissue, as in benign prostatic hypertrophy. Normal prostatic tissue and the outer capsule are left intact.

Tylectomy: Lumpectomy.

Ureterosigmoidostomy: A surgically-created anastomosis of one or both ureters to the sigmoid colon. In this form of diversion of urinary flow, there is no need for an appliance because the urine flows into the colon which acts as a kind of reservoir.

Vulvectomy: Excision of the vulva.

Appendix G – Cancer Abstracting Tips

Start by reading the H & P to find the signs and symptoms associated with the illness, details of any workup that has already been performed for this malignancy, past history of other malignancies and smoking history. Review all scopes, surgeries, histology & cytology reports, pertinent labs, x-rays, scans, ultrasounds, MRIs etc. to aid in determining the primary site as well as to identify the extent of disease for staging. Review the discharge summary and use as a guide but follow coding rules and principles to ensure proper primary site, histology, behavior & grade codes are assigned. Some cases will be a clinical diagnosis made by the physician based on lab, x-ray etc. findings and may never be confirmed by biopsy.

1. PRIMARY SITE

Use the ICD-O code manual to assign the correct code. Follow all general rules as well as site-specific rules in Multiple Primary and Histology Coding Manual to determine how many primaries/abstracts. Use all information available in the medical record to determine the site-try to be specific and code to the sub site if documentation is available.

2. HISTOLOGY/BEHAVIOR/GRADE

Refer to and follow all general as well as site-specific rules in Multiple Primary and Histology Coding Manual to determine correct histology.

Use the correct ICD-O code manual to assign the codes. All pathology and cytology reports for the case must be reviewed to determine the most accurate histology term.

Be certain of the behavior code-in situ (2) or invasive (3). Review the in situ terms often and become familiar with them. If even a **tiny focus** of invasion is documented on the path report the case is no longer considered in situ but invasive.

Always code the highest grade/differentiation when two are given.

3. DIAGNOSTIC CONFIRMATION

Determine if the case was confirmed microscopically or **not** microscopically.

Positive **histology** specimen (tissue from biopsy, surgery, autopsy, D&C and bone marrow biopsy/aspiration, peripheral blood smear) always takes precedence over positive **cytology**.

4. DATE OF DIAGNOSIS

Use the first date of diagnosis whether clinically or histologically confirmed. If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis. Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented. Use the actual date of diagnosis for an in utero diagnosis, for cases diagnosed on January 1, 2009 or later. If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown.

5. TREATMENT

First course of therapy is all treatment planned at initial diagnosis- sometimes this may take up to a year or more; treatment means cancer directed therapy that modifies, controls, removes or destroys primary or metastatic cancer tissue. Treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence “Active surveillance” is a form of planned treatment for some patients; its use is coded in the new RX Summ-Treatment Status item. “No

therapy” is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts or the physician recommends no treatment be given. If the patient refuses all treatment, code “patient refused” (code 7 or 87) for all treatment modalities. If the cancer progresses during treatment and the treatment plan is changed it is no longer first course of therapy- it becomes subsequent therapy; if the patient becomes disease free and then has a recurrence the treatment is always considered subsequent therapy.

Appendix H – Frequently Asked Questions (FAQ)

When did Health Insurance Portability and Accountability Act (HIPAA) become effective?

President Bush approved the regulations on April 12, 2001. The official effective date of the regulations was April 14, 2001. Covered entities, including hospital and physicians, had two (2) years to comply (by April 14, 2003), except for small health plans which were effective April 14, 2004.

What is a “Public Health Authority” under HIPAA?

Under HIPAA, a “Public Health Authority” refers to “an agency or authority of the United States, a State or territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors of persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.”¹ “...Such agencies are authorized by law to collect or receive such information for the purposes of preventing or controlling disease injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.”² Central cancer registries and hospital cancer registries if required to report cancer cases are considered public health authorities because state laws mandate their duties.

What is a “Covered Entity” under HIPAA?

A “Covered Entity” is a health care plan, a healthcare clearinghouse, or a health care provider who transmits any health information in electronic form for financial and administrative transactions. A “health care provider” is “a provider of medical or health services, and any other person who furnishes, bills or is paid for health care in the normal course of business.”³

What if a patient does not want follow-up information to be collected?

State-mandated cancer reporting typically does not require patient informed consent nor can individuals elect to be removed from reporting. In a state, which allows the collection of follow-up cancer data for public health purposes, it can be collected regardless of consent from a patient.

How does HIPAA impact the data collection of non-reportable/benign diseases (i.e. benign brain, CIN III, Co-morbid conditions)?

HIPAA does not obstruct any state law that supports or mandates the reporting of such cases.

Are private practice physicians still required to report new cancer cases?

Yes, in compliance with state reporting regulations. The central cancer registry has a reportable list that identifies which cancers are reportable, and all reportable cancers must be reported, as required by state law.

¹ C.F.R 164.501

² C.F.R 164.512

³ C.F.R 160.103 29

Will private practice physicians be permitted to continue to provide follow-up information to hospital cancer registries without patient consent?

Yes. Although private practice physicians are health providers, and thus covered under the provisions of the HIPAA privacy regulations,² there are several reasons why they can continue to provide follow-up information to hospital cancer registries without patient consent. First, the hospital cancer registry is an entity likely to be viewed as public health authority¹ acting under a grant of authority from or contract with a State, Tribal, or Local Public Health agency to provide for public health surveillance.¹

The HIPAA regulations specify that covered entities may use or disclose protected health information without the written consent or authorization of the individual...under specific circumstances. These include disclosures for public health activities and purposes to public health authorities authorized by law to collect or receive such information for the purpose of preventing or controlling disease or conduct public health surveillance.³

As public health authorities, hospital cancer registries are exempt from the HIPAA regulations and may continue to seek public health data from providers the same as before the HIPAA regulations were finalized. ADH did not attempt to interfere with state and local public health matters such as cancer surveillance through the implementation of these regulations.

Second, even if some hospital cancer registries are not public health authorities (because they are not associated with a state or local public health agency to work on public health matters), physicians may still have to provide follow-up information. HIPAA regulation Sec. 164.512(a) specifically states that: a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Thus, where a hospital cancer registry is required by state or local law to collect cancer data, physicians must follow the follow-up requirements of the registry to the exclusions of HIPAA privacy protections.

Finally, the consent requirement for disclosures under the HIPAA regulations does not limit the types of disclosures allowed. Provided a patient consents to the use or disclosure of his or her health data to a hospital cancer registry as part of the broader consent language, regularly sharing data between physicians and hospital cancer registries is permissible. In future cases, patient consents may specifically reference the sharing of data with all hospital cancer registries. For existing cases, written patient consent may also suffice for the purpose of authorizing these exchanges.

¹ 45 C.F.R 164.501 (2001)

² 45 C.F.R 160.103

³ 45 C.F.R 164.512 30

Is there specific legal documentation that supports the requirement to release cancer patient information to any agency?

Individual state laws and regulations document cancer reporting requirements. Central registries must be able to provide copies of their state's law(s) and regulations(s) upon request.

What, if any, are the consequences of not cooperating with state cancer registry requests for new cancer case information?

HIPAA does not obstruct any state law that supports or mandates the reporting of diseases or injury for public health purposes. Penalties for failing to comply with state reporting are specified in the state law and often consist of significant fines.

Doesn't HIPAA nullify the state law for reporting cancer cases to Central Cancer Registry?

No. Public health reporting under the authority of state law is specifically exempted from HIPAA rules.

Once HIPAA is in place, will pathology labs be able to continue to send new cancer case information to the state cancer registry?

Yes. Public health reporting under the authority of state law is specifically exempted from HIPAA rules.

Since HIPAA is federal will it override the state laws?

No. HIPAA does not obstruct any state law that supports or mandates the reporting of diseases or injury for public health purposes.

If the government-authorized public health entity is not located in the same state as the covered entity, is it still ok under HIPAA to provide the data?

Yes. In fact, the definition of a "public health entity" was broadened in the section "Uses and Disclosures for Public Health Activities," which states specifically "...We broaden the scope of allowable disclosures ...by allowing covered entities to disclose protected health information not only to U.S. public health authorities but also, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority."^{1, 2}

¹ F.R. p.82525

² 45 C.F.R. 164.512